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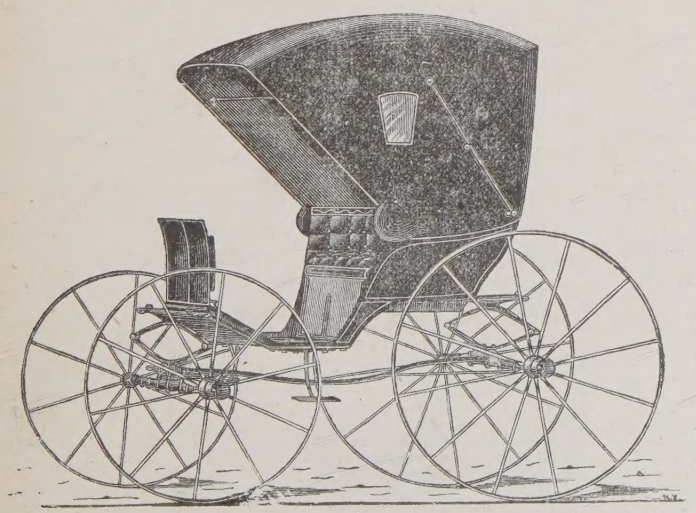

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INDEX TO VOLUME II.

Atresia Hymenatis et Vaginas. By Charles W. Adams, M. D., Kansas City 307
Acute Articular Rheumatism, an unusual treatment of 331
A New Law 315
A Happy New Year 322
A Column of Little Things 324
Again 325
A Correction 326
Antipyrin, alarming results from a single dose of 326
A Case of Poisoning from Cigarette Smoking 784
A letter 779
A Lecture, By W. L. Schenck, M. D. of Topeka 762
Academy of Medicine and Surgery 318
Alimentation in Adynamic—Conditions. By H. O. Beeson, M. D., Birmingham, Mo 345
Antiseptic Surgery. By W. A. Jordan, M. D., Wichita 348
Academy of Medicine and Surgery 353
Antifebrin in Tonsillitis 354
An Eye Wash 362
Antipyrin and Chloral—Incompatibility of 366
Anatomical 370
Abdominal Section—Abstract of a paper on. By M. B. Ward, M. D., Topeka 401
Acetanilid and Antifebrin 450
Anæsthetic 443
American Medical Association 477
About our Journal 483
Asepsis 473
Academy of Medicine and Surgery 485
Aural Sequelæ. By Grant Cullimore, M. D., Atchison 507
Aconite 520
A Lame Law 521
Ah, Fie! 523
American Medical Association 523
A Case 524
A Case. By A. B. Freeman, M. D., Wellington, Kas 544
Alcohol 557
Address on Medicine 561
American Medical College 564
Acetanilid and Antipyrin. By H. Redding, M. D., Vermillion 603
American Academy of Medicine. By W. D. Bidwell, M. D., Leavenworth 640
Acute Obstruction of the Bowels. By M. A. Brawley, M. D., Frankfort, Kas 642
A Case of Trephining for Epilepsy and Imbicility. By J. C. McClintock, M. D., Topeka 643
Abdominal Section—An 652
American Rhinological Association 652
An Insidious Cause of Disease 658
American Climatological Association 694
Asthma By E. S. McKee, M. D., Cincinnati, O 731
Blood Pressure in the Brain 780
Burns and Scalds. By W. W. Lucas, M. D., Hutchison 342
Book Reviews 401 373
Bacillus of Tetanus—The 783
Bile in Urine, Test for 410
Bill to Ally Illiteracy in Medicine 450
Blindness from Babies' Sore Eyes 522
Beware of Dog Carts 554
Bee Sting for Rheumatism 691
Chronic Ovaritis Versus Cystitic Ovaries. By H. C. Crowell, M. D., Kansas City 738
Chronic Cervical Endometritis. By J. W. McCracken, M. D., Sterling, Kas 299
Clinical Notes and Gossip from Kansas City Medical College. By R. S. Magee, M. D., Topeka 302
Curetting for Dysmenorrhoea 329
Coryza—Kara, the Head, and Zeo, I live 325
Chloral for Dandruff 327
Congenital and Zonular Cataract. By Grant Cullimore, M. D. Atchison 354
Chamber Pot 771
Castration of Criminals 363
Curse of our Schools—The 394
Clinical Notes and Gossips from Kansas City Med. College 399
Cod Liver Oil for Children 408
Crime, Its Physiology and Pathogenesis—and how can Medical Men Aid in its Prevention. By R. E. McVey, M. D., Topeka 450
Chronic Ovaritis. By H. F. Hornaday, M. D 499
Consumptive Tendencies 510
Chloroform Vindicated 533
Central Branch Medical Association 534
Cholera 569
Codeine, in Disease of Women 618
Chancre of the Ear 618
Cocoaine in Gastric Affections. By W. E. Shastid, A. M., M. D., of Wichita, Kansas 648
Cocoaine and Tobacco Smoke 702
Corneal Ulcers. By R. S. Magee, M. D., of Topeka, Kas. 691
Dislocated Spleen 714
Does the Practice of Medicine Pay? By J. H. Brierly, M. D., Glasco, Kas 366
Damage of Syphilis 451
Done Likewise 661
Death of Dr. Lobatut 777
Disagreeing Doctors 780
Doctor's Earnings—The 476
Diphtheria By B. W Harris, M. D 479
Disagreeing Doctors 505
Doctor Remembered—A 558
Disease of Women—Surgical. By S. Murdock, M. D., Oneida Kas 575
Delivery of a Retained Placenta 633
Digitalis—Indications for the Use of. By William B. Dewees, M. D., Salina, Kas 517
Epidemic Catarrh 709
Effects of our Late War on Soldiers 355
Epilepsy, Chorea and the Eye Muscles 332
Erysipelas, By L. D. Jacobs, A. M., M. D 371
Ergot in Obstetric Practice. By E. B. Shaw, M. D. Kansas City, Mo 754
Errors in Refraction. By Grant Cullimore, M. D., Atchison, Kas 767
Ether as an Anæsthetic. By J. M. Richmond, M. D., St. Joseph, Mo 383
Empyema, its Cause, Treatment and Recovery. By W. W. Cave, M. D., Oatville, Kas 455
Excerpts from Foreign Literature 556, 617
Eye Strain by the General Practitioner—The recognition of. By Edward Jackson, M. D., Philadelphia 504
Eastern Kansas District Medical Society 352, 559, 606, 744
Forensic Relations of the Puerperal State. By Harriet C. B. Alexander, M. D., Chicago, Ill 668
Fumigate Tuberculous Houses 463
Fracture of the Base of Skull 522
Foreign Body in the Throat 653
Forceps—The—A Death Trap 654
Formation of Urethral Stricture. By F. B. Browne, M. D., of Salina, Kas 661
Gynia, A new Disease 719
Gunpowder for Criminal Abortion 326
Gastric Ulcer, with Fibroid Induration of Pylorous or Cancer. By Chas. M. Mutz, M. D., Topeka 386
Gall Stones 392
Gunshot Wound of the Intestines 611
Glandular and Connective tissue—Hypertrophy of the Lateral Walls of the Pharynx. By Hal Foster, M. D., Kansas City, Mo 638
Genito-Urinary, System of the Male Neuroses—The of 688
Golden Belt District Medical Society 608, 742
How Much Should a City Pay its Health Officers 367
How to Cure Insomnia 370
Hydrastirine 411
How to Elevate the Profession 555
How to do Aseptic Surgery in Country Practice. By F. M. Daily, M. D., Scottsville, Kas 706
Hydroencephalocele—Congenital Tumors of the Brain. By D. R. Pelton, M. D., of Topeka, Kansas 678
Herniotomy 789
How Patent Medicine is Marked 781
Intestinal Obstruction. By L. Reynolds, M. D., Horton, Kas 312
Influenza 358, 426
Is this True of Topeka 364
Intestinal Obstruction 370
International Medical Annual 490
Intestinal Obstruction—Report of a Case. By J. B. Curtis, M. D. Lindsburg, Ks 542
Infant Feeding. By Deborah K. Longshore, M. D., Topeka 547
Interesting 563
Inducing Respiration 573
Intra Pelvic inflammation. By M. B. Ward, M. D., Topeka, Kas 384
Icthyol and its Uses 656
Idiopathic Phlebitis—Three Cases of. By D. F. Rodgers, M. D., Topeka, Kas 676
Intestinal Invagination. By W. L. Schenck, M. D., Topeka, Kas 674
Insanity as a Symptom of "Bright's Disease." By Alice Bennett, M. D., of Norristown, Pa 681, 726 773
Italy's Good Beginning 689
Jack o' the Lantern 436
Jottings. By Dr. Draper, Osage 552
Japan a Highly Syphilized Nation 657
Kansas Medical College—The 559, 648, 692
Knife Wound of the Stomach. By H. H. Sutherland, M. D., Liberal, Kas 351
Koch's Method 781
Koumiss, Kefir and Matzoon 429

Kansas City Medical College Commencement ... 435
Kansas Medical Society ... 476, 479, 529, 524, 567
Leavenworth Medical Society ... 321
Lucky Kansas ... 362
Lawson Tait on Fibroids of the Uterus ... 362
Little Things ... 438, 474, 527, 560, 614, 650, 693, 739, 396 778
Leavenworth Medical Society ... 391 782
Local Medical Societies in Kansas ... 615
Labette County Medical Society ... 646
Little Things we have Noticed Lately ... 735
Malarial Fevers—an Infallible Antidote for ... 328
Medical Education ... 360
Malarial Keratitis—Report of a Case ... 394
Medicine in Syria ... 426
Medical Society of the Missouri Valley ... 781
Medical Dictionary—A New ... 490
Missouri Valley Medical Society ... 484, 698
Morphine for Snake Bite ... 617
Metric System ... 647
Major Pelvic Troubles. By Joseph Price, M. D ... 725
North East Kansas Medical Society ... 318
North Eastern Kansas Medical Society ... 363
Needed Pension Legislation ... 363
North Eastern Kansas District Medical Society ... 444
Notes on Infant's Food ... 525
Nervous Diseases Produced by Lightning ... 573
Neurasthenia ... 576
New York Polyclinic ... 659
New Journals ... 990
Neuralgia and its Treatment. R. E. McVey, M. D., of Topeka, Kas ... 722
Our New York Letter ... 368, 398
Obituary ... 441
Obstetrics and Gynecology. By E. S. McKee, M. D., Cincinnati, Ohio ... 550
Ocular Surgery. By G. A. Wall, M. D., Topeka ... 23
Phenacetin ... 329
Paraldehyde as a Hypnotic ... 354
Page of Little Things ... 359
Program of State Medical Society so far as Completed ... 362
Philadelphia as a Medical Center. By M. B. Ward, M. D., Topeka ... 589
Psalm of Life—A New ... 407
Pruritis. By W. L. Schenck, M. D., Topeka, Kas ... 418
Placenta Previæ. By D. R. Pelton, M. D., Topeka ... 422
Polypus in a Virgin ... 432
Proprietary Medicine ... 433
Physicians and Druggists—The Relation of ... 437
Program of State Medical Society ... 439
Pasteur Institute in New York ... 441
Pneumonia. By J. H. McCasey, M. D., Concordia, Ks ... 458
Pneumonia. By L. R. White, M. D., Scandia, Kas ... 461
Preparation for Motherhood. By M. R. Mitchell, M. D. Topeka ... 467
Phthisis. By W. D. Bidwell, M. D., Leavenworth, Ks ... 470
Program of the State Medical Society ... 482
President's Address. By C. C. Green, M. D., Topeka ... 491
Pleuro-pneumonia following La Grippe ... 532
President's Address. By I. N. Love, M. D., St. Louis, Mo. ... 539
Pott's Fracture. By L. J. Lyman, M. D., Manhattan ... 545
Perineorraphy. By N. N. Gardner, Greenleaf, Kas ... 551
Puerperal Peritonitis ... 571
Physician's Instinct—The ... 575
President's Address. Joseph Haigh, M. D., Granada ... 628
Powered Jequirity in Certain Affections of the Eye—The use of. By W. Cheatham, M. D. ... 671
Painful Menstruation in Virgins. By I. N. Love ... 673
Patent and Proprietary Medicines ... 696
Quinsy ... 354
Quinine in Pregnancy ... 776
Quinine and Antifebrin ... 403
Quinine in Pregnancy ... 410
Report of a Case. By C. A. McGuire, M. D., Topeka ... 297
Rascality in Medicine ... 332
Republican Valley Medical Society ... 395
Removal of a large Sarcoma. By John A. Wyeth, M. D., New York ... 413
Reprints Received ... 777
Regular Profession—The ... 439
Railroad Rates to the State Medical Society ... 440, 472
Republican Valley District Medical Society ... 484
Relation of Formative matter to Disease. By J. F. Foote, M. D., Wichita, Kas ... 493
Railway Hygiene ... 519
Report of the Stormont Library Committee ... 570
Reprints Received ... 690, 575, 737
Reports on the Progress of Ophthalmology. By D. F. Longenecker, M. D., Emporia, Kas ... 596, 619
Rhino Pharyngeal Diseases. By W. E. McVey, M. D., Topeka, Kas ... 600
Report of a Case ... 616
Reflexes as Aids in Diagnosis. By Charles Gardiner, M. D., of Emporia, Kansas ... 630, 663
Report of a Case of Misplaced Confidence ... 660
Rest in the Treatment of Tetanus ... 660
Resolutions on the Death of Dr. D. J. Holland ... 695
Radam's Microbe Killer ... 697
Rupture of the Membranes ... 703
Republican Valley Medical Society ... 740
South Kansas Medical Society ... 316
Stricture of the Urethra—Diagnosis and Treatment. By W. A. Righter, M. D., Topeka ... 349
School of Dissection ... 364
Some Recent Additions to Materia Medica ... 373
Scarlet Fever—Symptoms and Diagnosis. By Theo. Peers, M. D., Topeka ... 375
Sanitary Instruction in Schools and Colleges. By W. L. Schenck, M. D., Osage City, Kas ... 379, 23
Shoe Button in the Nose four years ... 383
Scarlet Fever, Diphtheria and Croup ... 409
Standardizing fluid Preparations ... 412
Syphilitic Epididymitis. By G. W. Davis, Kansas City 426
Stevens Operation—Remarks on. By G. A. Wall, M. D., Topeka ... 466
Symmetrical Education ... 480
Stockholders Meeting ... 482
South Kansas District Medical Society ... 531
Spinal Concussion ... 532, 69
Stories of a Country Doctor ... 3
Senn's Hydrogen Gas Test. By A. H. Cordier, M. D., McPherson, Kas ... 6
Summer Diarrhœa. By C. C. Green, M. D., Topeka ... 6
Some Therapeutic uses of Buttermilk ... 6
Summer Heat a cause of Disease in Children ... 6
Sewage Disinfectant—A New ... 6
Sweating Feet—A remedy for ... 6
Suspension Treatment for Locomoter Ataxia. By O. C. McNary, M. D., Soldier's Home, Leavenworth ... 625
Surgical Treatment of Empyema ... 785
Suppurative Hepatitis—With Report of Case. By A. B. Peters, M. D., Mankato ... 636
Sarcoma of the Kidney ... 655
Summer Drinks of the Moguls ... 689
Stricture of the Urethra. By A. H. Cordier, M. D., McPherson, Kas ... 747
Sad Indeed ... 737
Sixth District Medical Society ... 746
Tobacco—Its Effect on the Eye Sight. By Flavel B. Tiffany, M. D., Kansas City ... 336
The Water Supply of Leavenworth. By Charles R. Carpenter, M. D. ... 749
The Honors that Await the Discovery of Surgery—Poem ... 368
Tenth International Medical Congress ... 369
The Hypodermic Needle ... 369
The Necessity for a Higher Standard of Accuracy for Toxic and Narcotic Drugs ... 372
Treatment of Ingrowing Toenail ... 372
Tact in a Physician. By J. E. Minney, M. D., Topeka ... 414
Three Years Course ... 563
Test of Diet ... 555
Two Interesting New Drugs ... 649
Treatment of Spermatorrhœa. By Emory Lanphear, M. D., of Kansas City, Mo ... 685
Three Double Births ... 737
Topeka Academy of Medicine and Surgery. 391, 447, 528, 565, 605, 699, 645, 743 ... 782
Uniform State Legislation ... 393
Uterine Dysmenorrhœa. By F. F. Dickman, M. D., Ft. Scott, Kas ... 535
Vaginal Tampons, By J. C. McClintock, M. D., Topeka 335
Valedictory Address ... 512
Vesical Catarrh—Treatment of ... 574
Veratrum Viride in the treatment of Eclampsia—The Merits of ... 665
Wilson County Medical Society ... 353
What Shall my Subject be? ... 366
Warning—A ... 394
Weak Heart and its Treatment ... 410
What Shall the Subject be? ... 480
Where Shall I Graduate ... 562
Wichita Medical College ... 562

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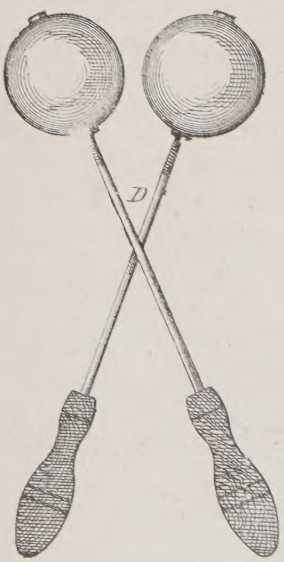

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Report of a Case.

FRACTURE OF THE SUPERIOR MAXILLAE, INVOLVING THE RIGHT ANTRUM.

Read before the Academy of Medicine and Surgery, at Topeka, November 5, 1889.

BY C. A. M'GUIRE, M. D., OF TOPEKA, KAS.

September 19, 1889, Mr. Thos. F. Irish, aged 28, a conductor of the Rapid Transit railway company, while standing in a stooped position on top of a car adjusting the spring of the trolley arm, which makes the connecting current with the overhead wire, was struck a crushing blow across the face on the right upper lip by this spring, which is extremely powerful, flying out of its position. The blow was of such force that it would have knocked him off the car if he had not been caught by an assistant. He was taken to the central station, some twelve blocks away, where I saw him at 9 p. m., which was about one hour after the injury was received. I found a slight cut three-quarters of an inch long below the right ala of the nose, extending down and out, but not extending through the lip. This was the only external abrasion, but the patient was bleeding profusely from the mouth and anterior and posterior nares. The eyelids were nearly closed by the swelling, and the right upper lip was swollen to such an extent that it was about one and one-half inches thick, and the inner surface of the same was torn loose from its alveolar attachment, so that it dropped from one-half to three-quarters of an inch. I administered a small dose of stimulants, and used *hot* water freely for an hour, to check the hæmorrhage. In order to examine the mouth it was necessary to incise the inner surface of the right upper lip, nd expel the blood clots, so as to introduce the finger into the mouth. I found a fracture of the superior maxillae extending from the outer border of the right superior maxilla, diagonally up and inward across the body of the bone, between the alveolar and malar processes, through the right antrum to the nasal cavity above the right palate process, obliquely down and across, fracturing the left palate process through its posterior half, and obliquely down and out through the left maxilla between the first and second molar teeth, leaving the lower portion of the superior maxillae freely movable, and dropped as beforementioned one-half to three-quarters of an inch more marked on the right side, and pressed slightly backward and to the left. Manipulation of the parts caused pain at the

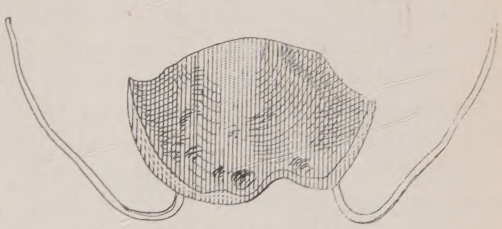

FIGURE I.

See next page.

inner angle of the right eye, otherwise he complained of but little pain. During this time the patient was fully conscious, but was suffering slightly from shock, with a slow pulse and a strong inclination to sleep, and frequently asked to be let alone.

The swelling about the mouth and lips was so great that the patient was unable to take any nourishment except through a glass tube, and through that he took another dose of stimulants, and was then removed to the hospital where he was made comfortable, and the displaced fragments were adjusted as well as possible by the fingers. No bandage was applied, nor any attempt made to use the lower jaw as a retaining splint, because the hemorrhage was still so profuse that the patient was

compelled to keep the mouth open for drainage, and to expectorate the blood.

I ordered a *hot* solution of boracic acid as a

FIGURE II.

wash for the mouth, and anterior and posterior nares, and compresses of distilled extract of hamamelis applied externally.

September 20. The right eye lids were entirely closed, and left eye lids nearly closed by the swelling, and both eyes and the right side of the face were of a purple hue. The patient was suffering but little pain; pulse slightly accelerated; temperature 99½°. The hæmorrhage was still quite profuse. Patient was able to take sufficient milk and whisky through a tube.

September 21 and 22. Condition and treatment of the patient was much the same, but the hæmorrhage was gradually growing less, and pulse and temperature were normal.

September 23. Dr. W. A. McCarter, a dental surgeon of this city, was called in consultation, and we decided to continue the same plan of treatment until the swelling of the parts had subsided sufficiently to make an impression of the mouth, and then apply an interdental splint with external support.

In the following five days the patient was able to take fluid nourishment without the aid of the glass tube, and the swelling of the parts subsided so that September 28 the doctor obtained an impression of the upper and lower jaws with moulding compound, a substance that softens in hot water, and is used by dental surgeons for such purposes.

He made a hard rubber plate from this cast of the upper jaw with square steel wires, $\frac{3}{16}$ of an inch thick, fitted into square sockets at each side of the plate external to the teeth, so as to come out at the angles of the mouth, curving back and passing horizontally along the sides of the face for about 2½ to 3 inches.

This plate, (Fig. I.) was adjusted September 30, and retained in position by bandages applied in the manner indicated in Fig. II.

This plate, by the tension of the bandages, gradually pressed up the displaced parts to their proper position, elevating them one-half to three-quarters of an inch from their position before the adjustment of the plate; and, as a result of this elevation, it was necessary from time to time to adjust, curve and mould the steel wires to fit the angles of the mouth, as indicated in Figs. I. and II., by the peculiar curvatures of the wires in the plate.

The patient complained slightly for the first few days owing to the pressure of the plate, which caused some tenderness of the teeth, and some pain below the inner angle of the

FIGURE III.

right eye, which is, I believe, a common occurrence in such cases.

There was some offensive discharge from the right antrum into the right nasal cavity, which made it necessary to remove the plate, and use antiseptic and cleansing washes every two or three days. While the plate was in position the patient was able to go down town, and could take fluid and semi-fluid nourishment with comfort.

The plate was left in situ until October 20, when it was removed in the presence of Drs. Guibor, Alexander, Munn, McCarter, and myself. The patient was examined by all present, and we found perfect union without deformity, loss of tissue, teeth or motion, except the right upper lateral incisor, canine and first bi-cuspid teeth were pressed slightly inward so the articulation was not perfect; but the patient was directed to use occasional outward pressure on these teeth, to use only soft foods, and be careful of the articulation, in masticating any food; also to use the mouth washes for a few days. The patient was seen a few times until October 26, when he was discharged. His appearance at that time being indicated by Fig. III. October 28 he resumed his work, and now his articulation is as perfect as before the injury was received.

Chronic Ovaritis Versus Cystic Ovaries.

BY H. C. CROWELL, M. D., KANSAS CITY, MO.

The object of this paper is briefly to consider certain positions and takings, in a paper read before the South Kansas District Medical Society, held in Wichita, May 14, 1889, and reported in the July number of the *Kansas City Medical Record.*

I have been prompted to a consideration of the paper above referred to, believing that it was not founded altogether on facts and consequently must be more or less misleading, especially to those whose opportunities of observation of like cases shall have been more limited than those of the writer above referred to. First, then, in order that the reader may the better understand the full intent of this paper it will be necessary that we quote verbatim or in substance the assertions of the paper under consideration.

The author entitled his paper "Cystic Degeneration of the Ovary," and assumes first, "That you must have often met with it in your practice," which fact we think you will settle adversely in your own minds without long comment since it is acknowledged by competent authority to be seldom recognized before removal. Many ovaries contain ten or twenty cysts or more and yet are so small and associated with so little structural change as to attach no significance either clinically or otherwise. Even some of the larger, simple cysts, whose walls are very thin are with no little difficulty diagnosed before removal either through the rectum or vagina, save in some very exceptional cases.

The next statement made by the writer is "That you have probably read very little upon this subject in your works on gynæcology," which implies either that you have been a poor student, or that the literature is very meagre on the subject, and he further expresses surprise that so little has been written upon diseased conditions of the ovary, while other diseased conditions of the generative system of women have received much learned attention, and attributes this neglect to the fact "That book-makers are not as a rule, objective students of medicine, especially at the bed-side or in the post mortem room." In answer to this statement we beg leave to refer the writer of the paper to such works or workers as Tait, Olshausen, Schroeder, Emmett, Thomas, Wiley, Polk, Goodell, and others, all of whom we are compelled to believe are emphatically students of objective medicine and no mean pathologists.

He further refers to the pathology assuming that "It is involved in a good deal of obscurity at present and is probably dependent on a good many causes or at least more than one." We cannot better express the substance and concerted opinion of numerous pathologists and gynæcologists, especially, who have written upon this subject of cystic disease of the ovaries, than by quoting W. Gill Wiley, of New York, who says, "Cystic disease if it exist is due to long continued congestion of the ovary, intestinal inflammation following slowly. The successive phenomena in the history of these cysts of the follicle, are, hypergenesis of the epithelial elements, sclerosis

of the follicular walls, degeneration of the epithelium, liquefaction of the exuded or retained exudate and hemorrhage." No obscurity seems to exist in the minds of these authors; all agreeing that cystic degeneration of the ovary is due to dilatation of the graafian follicle being easily traceable, even to those of large size. Schroeder shows that ovaries which are situated beneath peritonitic callosities are not infrequently infiltrated with small cysts, due probably to the fact that it prevents rupture of the follicle.

The paper further states that "It is never known before puberty nor after the menopause." That there are exceptions will be seen by referring to works upon the development of graafian follicles which show that they are formed often long before the birth of the child, sometimes presenting dropsical conditions or distensions producing cysts of a very considerable size in very young children. These statements are vouched for by Curllinworth, Virchow, DeSinety and others.

At this point the author inserts a comparison between cystic ovaries and ovarian tumors. It is apparent to every one that in order that either condition obtain there must be a disturbed condition of histological elements, in explanation of which, the author of the paper informs us "That ovarian cysts do not begin in the graafian follicle, but in the ovarian stroma," in answer to which we would refer to the classification based upon the opinion of all pathologists of distinction previous to 1886, as follows:

First.—Distention and coalescence of graafian follicles.

Second.—Degeneration of undeveloped graafian follicles, (ordinary multilocular tumors.)

Third.—Development of remnants of the wolffian bodies in the hilum of the ovary (papillomatous tumors.)

Fourth.—Malignant development of connective tissue of the ovary.

These four classifications represent the combined and established opinions of to-day. Thus we see that none of these authorities admit of an implication of the ovarian stroma save in the malignant form which does not concern us in this connection. In further proof of the fact that ovarian cysts do not originate in the ovarian stroma permit us to quote Olshausen, who says, "It would be well-nigh impossible for us to regard the large cysts as dilated graafian follicle, were it not for the fact that every possible gradation may be observed between them and the very smallest cysts. In addition ovula can be detected in the smaller cysts."

The entire sentence from the paper under consideration reads, "*the ovarian cysts does not begin in the graafian follicle, but in the ovarian stroma, and is therefore closely allied to the connective tissue tumors with glandular hydræmia.*"

The last clause is contradictory and ambiguous, not expressing any comprehensible or, recognized pathological condition, since connective tissue tumors can not be associated with *glandular* hydræmia in as much as they contain no glandular structure and since hydræmia signifies simply watery blood. We think further comment unnecessary to demonstrate the exact similitude in pathological origin and character between cystic ovaries and ovarian tumors, and since we fail to observe the difference histologically or pathologically, we can not grasp the signifiance of comparing cystic ovaries with ovarian tumors, nor are we able to ascribe these symptoms to cystic ovaries or does the author in his table of comparison.

Many diseased conditions of the ovary are so nearly allied that a differentiation becomes a task such as few are competent to undertake being as they are obscure in symptom and removed from easy access to the obscure, That such is the case is simply evident when we peruse the literature upon the subject. What almost innumerable operations have been performed for the relief of neuroses supposed to have their origin in the ovaries? and what has been the result in by far the larger majority of operations? The ovary has only presented evidence of health when viewed macroscopically and microscopically, presenting no diseased condition save perhaps a few cysts such as are found in all ovaries removed during the period of sexual activity. The result of such operations has also demonstrated that the neuroses for which the ovaries were removed still remain in a large per cent. of such cases, though some are benefited

beyond a doubt. The most common condition found however, consists in a hyperæmia or chronic ovaritis. This condition becomes so prominent that we can dismiss from consideration those changes resulting in the formation of cysts which are not accompanied, per se, by reflex nervous symptoms.

Among the large number of neuroses caused by ovarian hyperæmia or chronic ovaritis may be mentioned vaso-motor and cardiac disturbances, hysteria, epilepsy, mania, melancholia, neuralgias, spinal irritations, irritable bladder, rectum, &c., &c.

Since we have seen that chronic ovaritis is the cause of far the larger part of the suffering and subjective symptoms to be ascribed to ovarian disease, it may not be amiss to compare some of these symptoms with those of cystic disease of the ovaries as set forth in the paper above referred to, (see comparative table herewith.)

CYSTIC DEGENERATION OF THE OVARIES.

First—Always very painful.
Second—Pain greatest at menstrual period.
Third—Menstrual flow usually increased and prolonged.
Fourth—Pain begins with the congestive stage of menstruation and ceases with its cessation.
Fifth—Never begins until puberty is reached.
Sixth—Ceases with the cessation of the menstrual function.
Seventh—Is entirely painless during pregnancy and lactation, if such should occur.
Eighth—Comes on suddenly and usually with great violence, though not always.
Ninth—Symptoms are those of actual inflammation at the beginning, or when new growths occur.
Tenth—The patient generally supposes that she has inflammation of the womb, or some displacement, and is generally treated for it.
Eleventh—Touch of the womb is painful.
Twelfth—Rectal touch gives great pain, especially when the ovary is pressed upon.

CHRONIC OVARITIS—OLSHAUSEN.

First—Fixed pain in one or both ovaries.
Second—Pain severe, usually lasts through menses, most severe first two days.
Third—Menstruation generally disturbed and excessive.
Fourth—Pain most severe first two days of menstruation.
Fifth—Occurs almost exclusively during period of sexual activity.
Sixth—Disease is protracted lasting sometimes for years.
Seventh—the same obtains in chronic ovaritis.
Eighth—Not always, applies to both conditions in the larger proportion of cases.
Ninth—Usually begins as acute ovaritis or in some adjacent acute inflammatory disease.
Tenth—Patient generally arrives at conclusions agreeing with her social position and environments. Is treated as her physician in his wisdom deems advisable.
Eleventh—Touch of the womb causes pain by causing a strain or pressure upon ovaries.
Twelfth—The same holds true in ovaritis.

Since comparing the above symptoms we are struck with their similarity and the probable impossibility of an easy diagnosis of cystic degeneration of the ovaries from its clinical history, and it becomes the more so when we remember that the very large majority of so-called cystic ovaries demonstrate but minor development of cysts, large cysts being found but once in 200 cases or perhaps less frequently.

Under differential diagnosis the author states that versions or flexions may be confounded with cystic disease of the ovary, fibroids, &c., which would seem to be a strain upon the imagination. He recommends Sims' position for the examination and differentiation as well as for the purpose of determining the size of the organ, whether cysts exist and if adhesions are present, asserting that as good and complete a knowledge may be gained by such examination as one could obtain of articles on a table with his eyes blind-folded and a glove on his hand.

First in regard to Sims' position; the principle which prompted the invention of the speculum and position bearing the name of Sims, contraindicates its utility for purposes of diagnosis in this particular instance since a gravitation *from* us renders organs under any condition inaccessible, less so, hence we would recommend the dorsal position aided by the Volsellum forceps attached to the cervix uteri thereby enabling us to draw down the

uterus and its appendages within a possible reach in a large majority of cases. We are compelled to believe that there was a lack of seriousness on the part of the author of the paper when he asserted that these diagnoses were as simple as determining articles upon a table with eyes blind-folded and a gloved hand. Certain it is that my own experience and observation which has not been limited, does not endorse such a statement, and that our most eminent gynæcologists have been chagrined to find no adhesions where they had been anticipated and confidently expected, and vice versa.

If now we should concede to cystic disease or degeneration of the ovaries the same symptoms as obtained in chronic ovaritis, what is to be the treatment? The author would lead us to believe that there was but one alternative, namely extirpation. Shall we extirpate at once? Experience teaches that many of these cases of chronic ovaritis may be, if not cured so ameliorated, that life is bearable and thus avoid subjecting them to the dangers of abdominal section. The operation of laparotomy as introduced by Hegan, Sail and Battey, has been a great boon to suffering women when judiciously applied, but it was not introduced for castration of every woman who should suffer from some ovarian disturbance, nor especially for the removal of cystic ovaries.

We have found that the cystic condition was discovered after operations had been performed, and that no symptoms could be fixed upon cystic ovaries of themselves independent of other diseased conditions. Such was the case in Hegan's first operation, the cyst being found after the removal of the ovary.

All cases presenting symptoms sufficient to suggest operative interference should be thoroughly analyzed, eliminating all causes other than those of local character, especially the inherited tendencies.

Finally, the deductions which result from this analysis of conditions in hand are these:

First—That one should exercise great care in presenting a scientific subject, that its history and means of recognition be clear and distinct, capable of application and appreciation by those who have a reasonable amount of knowledge upon such matters, thus avoiding failures in such attempts, which, thereby bring discredit upon the profession at large.

Second—That certain physical conditions found in the ovary in the form of cysts are not of great clinical importance, and as usually observed are unrecognizable by the average or even the best physical diagnosticians.

Third—Making diagnosis so eminently easy in conditions which, to our best talent are not easy, is misleading and destined to confuse those who undertake it.

Fourth—To refer those who are interested in the subject to the literature, before accepting statements which carry a shadow of doubt to every reasoning mind.

Fifth—An endeavor to bring the pendulum back to a median position from which it has swung, with some, so strongly in favor of castration, for every vague and undefined ovarian disturbance.

Chronic Cervical Endometritis.

BY J. W. M'CRACKEN, M. D., OF STERLING.

Read before the South Kansas Medical Society at Newton, Kan., Nov. 11, 1889.

The disease entitled as above, with its intimately associated morbid conditions, probably requires more study and attention from physicians than any other one disease with which woman is afflicted. As woman, from the time she reaches puberty on through all the mutations of her checkered career, until she passes the climacteric, absorbs a large share of the physician's time and study. So does the above designated disease, and associated ills, demand a large share of the time, labor and thought of the gynæcologist. It would be impossible to intelligently consider chronic cervical endometritis without giving attention to the corporeal extension of the same disease, also the several conditions that exist either as cause or effect. Cervical endometritis may exist without corporeal, but rarely the reverse. Aran West, Byford, Chauncy D. Polman. T. D. Thomas and others, claim that chronic cervical endometritis is the most frequent of all uterine diseases, while its corporeal extension or involvement is rare. Tilt and Klob declare the latter quite common. It matters

but little for our purpose as to these fine distinctions, as to the preponderance of diseased locality, only so far as it shall influence our judgment in diagnosis or our adaptation of treatment. In thus electing to place the involvement of the cervical canal prominently before you I would not forget the gravity of the corporeal trouble when it does exist. Dolins holds "that endometritis is necessarily the starting point of every parenchymatous inflammation of the uterus or peri-uterine tissues, and that when such lesions of these tissues disappear, chronic endometritis usually remains." Dr. Palmer, Am. Sys. Gyn., says "It is more than probable that chronic inflammation of the mucous membrane of the cervical canal and the exterior of the infra-vaginal cervix is the most frequent disease of the female pelvic organs." James H. Bennett says "inflammation of the cervix, and especially of the mucous membrane which covers it and lines its cavity is so common as to form a prominent feature in uterine pathology;" and further, "that such should be the case is a necessary consequence of the anatomical and physiological conditions in which the uterus is placed." Dr. T. G. Thomas claims "that of all the diseases of the genital system of the female this is without doubt the most frequent, and although not in itself a malady of dangerous character, may prove the starting point for some of the most serious and rebellious of uterine disorders." The occurrence of chronic cervical endometritis following an acute metritis, subinvolution, areolar hyperplasia, or corporeal or general endometritis is certainly explicable on reasonable grounds. When we take into account the difference in structure existing in the body and cervix, coupled with the exposed relations of the cervix to other parts, as the rectum loaded with hard and fæcal matter; the womb pressed down by its increased weight, and the pressure of corset and skirts; the cervix resting on tissues acting to close the os, to the passage of normal or pathological secretions; their retention within the cavity of the neck, with its folded and reticulated mucous membrane and deeply imbedded glands with thin patulous mouths. Also from injuries during coitus or labor and the extension of gonorrheal inflammation.

According to Dr. Palmer the steps in pathogenesis are:

1. Increased and altered secretion, incident to the changes in the Nabothian glands.

2. Erosion of the epithelium.

3. Granular degeneration of the villi of the mucous membrane.

4. Dilatation to the os externum and lower cervical canal.

5. Eversion of the cervical mucous membrane.

6. Follicular ulceration and degeneration.

While this may be the usual order of symptoms in which morbid action is manifest, they are not necessarily present in all, or even a majority of the cases which we are called upon to treat.

In regard to the pathology of cervical endometritis there seems to be more harmony than exists among authors in regard to many other morbid conditions. It is primarily a glandular affection or inflammation. The glands of Naboth "become swollen, enlarged, elevated, with dilated mouths, and in consequence there is a hypersecretion." This first is thin, glairy, alkaline, like the white of egg, then thicker, more tenacious, and adhesive; still later, albuminous, loaded with epithelial cells. May change to yellow and be tinged with blood. In the vagina it may be found white and coagulated like hardened white of egg. Its acrid charcter cannot be overlooked; frequently causing erosion of the lower lip (posterior) of uterus. In this disease we have clearly marked predisposing and exciting causes: the former consists of

Natural feebleness of constitution.

The various diatheses and blood diseases.

Impoverishment of system from any cause.

Excessive lactation.

Frequent parturition.

Use of instruments.

Subinvolution and too hasty getting up after confinement.

Acute endometritis.

Versions and flexions.

These various conditions act to disturb the nervous system, interfere with the circulation and nutrition of the lining membrane of the uterus and specially that of the cervix.

Exciting Causes may be enumerated, principally as follows:

Excessive or intemperate coition.

The use of pessaries, especially stem.

Endometritic puerperal or non-puerperal.

Hard labor and constipation, with a subinvoluted uterus.

Efforts at production of abortion and prevention of conception.

Vaginitis, simple or specific.

Excessive manipulation during labor in aid of dilatation.

Laceration of the cervix.

In addition to the usual list of predisposing and exciting causes we have to add the suggestion of a third. Boleris in An. Uni. Med. Sci. for 1889, considers that it may be due to exterior causes, represented by certain pathogenic organisms or traumatism. Verchère, Annual, as above, holds that all forms of endometritis are infectious, and that they take their origin from a point of infection from some pathogenic organism introduced into the vagina or uterus, and his views are, in a measure, supported by the researches of Winter, who has determined that, while micro-organisms are always found in the vaginal and cervical canal, they do not exist above the internal os except with a diseased mucosa.

Chronic cervical endometritis is often so slow and insidious in its inception and progress, that it may exist for considerable time and the woman be unaware of its presence. Even an abundant leucorrhœa fails to attract attention, and when she is questioned in regard to its existence her answers will be mainly negative, only just enough admitted to keep the physician on his guard and cause him to seek a full investigation, when *all* the facts necessary to a definite diagnosis are easily obtained. One of the first symptoms which usually attracts attention is an excessive leucorrhœa, acompanied by a sense of dragging weight with bearing down sensation in the pelvis, incurred by standing or walking. This may be accompanied with pain in the back, pain on the top of the head, and all of the above may be aggravated during menstruation.

Tenderness and pain during coitus, or an instrumental examination is not necessarily a symptom of trouble in the cervical canal, unless associated with cervical hyperplasia or other form of inflammatory disease.

Menstruation may be deranged, more frequent, less excessive, frequent, painful with varying character and quantity. As to the influence of the local disease on the constitutional condition, it will be plainly manifest in time, some sooner than others. All the vital functions are disturbed. Yet notwithstanding the diseased mucosa, the deranged menstruation and disordered general health, conception frequently takes place and healthy children are born at quite natural labors.

Physical Signs.—By touch. The uterus is usually found very nearly in its normal position, though often depressed to the utmost, with the os almost out of neck and patulous. Tenderness is not marked in cases where no complication exists. The cervix may be found enlarged, puffy, nobular and irregular from lacerations. If pain or tenderness is evinced, to any marked degree, a certain amount of inflammation or cervical hyperplasia must be present.

By speculum. The cervix well exposed, the os will be found bathed in secretion, from the typical white-of-egg looking glairy mucus to that closely resembling pus, with occasional mixture of sanies or shreds of mucous membrane from the body of the womb. An effort at removal of the first described product will confirm the former opinion, if additional proof is necessary, as it will be found very difficult of removal. If the disease has passed on to one in which pus is found, we will probably find abrasion or erosion of the mucous membrane, by removal of epithelium, leaving a reddened and raw looking area—it may be only a limited space, or it may cover a large share of the most dependent part of the cervix. The cervix may present an extreme puffy condition even to the extent of two inches or more in diameter, without ulceration or abrasion.

The sound. If the sound passes freely into the body of the womb, it may be safely asserted that the morbid action extends to that cavity as well. It is certainly proper, in every case, to make intelligent use of the sound. Where much tenderness is manifest, *great care*

should be taken not to do harm, but it is always good practice to make every examination just as full and complete as possible, thereby preparing ourselves for any complication that may arise in the treatment of the case. If great tenderness is found, with hemorrhage easily started, and increased weight of womb, we may be positively certain that, while we may have chronic endometritis, we also have general utritis, or, more concisely, one of areolar hyperplasia according to Thomas; or, if within one or two years after labor, one of subinvolution as a farther complication. I would summarize the most prominent symptoms under two heads: first, those necessary to call for and justify an examination, and those found by an examination. The first class comprises those elicited by inquiry, as follows: a decided leucorrhœa extending from one period to another; pain on top of head, disturbed stomach, dragging weight and bearing down of pelvis, tenderness and pain during coition, and may be vesical disturbance, also deranged menses, or not. Second, upon an examination, digital—the os commonly low down and womb in condition of anteversion, os frequently soft and puffy to feel, or may be of a nobular feel from laceration or enlarged Nabothian glands, tender to touch. Examination with speculum, vaginal walls frequently dark and flabby from loss of tone; os sometimes enlarged to a degree making it difficult to bring into the speculum. May be puffy or very puffy—nodular or hard. Secretion profuse; that already in the vagina being white, a floculent or lumpy, that hanging from the os of a glairy, white-of-egg appearance and very difficult of removal. The mucous membrane may be eroded or ulcerated, most commonly the posterior lip of the cervix has the most extensive erosions. If a puffy cervix is found there is generally a patulous os, and where the cervix is hard, or free from cervical hyperplasia, there is most commonly a more natural condition of the os or even a constricted one. The above comprise the principal features of an uncomplicated case of cervical endometritis. Many peculiarities will be met in this line of investigation. We may find a conical cervix, or a pinhole os, with disease confined strictly to the cervical canal, either of which conditions are sufficiently rare to elicit surprise.

Treatment.—It might almost be written as an axiom that all chronic diseases, however local, soon leave their impress on the constitution, and this being so very true of the disease under consideration, it is eminently proper to first look to the constitutional condition and its treatment. As a rule we will find a weak condition of stomach, poor appetite and poor digestion, and poorer assimilation, and a consequently defective sanguification. The nervous system will frequently be as manifestly faulty. A tender spine, with perverted sensation, neuralgic pains, and loss of memory, and inability to secure good sleep, will clearly point to cerebral and spinal anæmia as an outgrowth of constitutional poverty, or as one of its prime factors. The above, with obstinate constipation added, will all demand attention. I will give my treatment in a typical case as above enumerated, hoping some one will present a better line than the one here indicated.

For the constitutional wants,

℞. Syr. hypophos comp. with iron, ℥ iv.
Dil. phos. acid ℥ j
Pepsin, scale, grs. xxx
Liquid malt qs. ad. ℥ viij
M. Sig. Teaspoonful in water before meals.

Also ℞. Quinia sul. grs. xl
Ferri phosphus, grs. xx
Zinc phosphite, grs. x
Ext. nux. vom. grs. x
M. ft. capsules No. 40.

Sig. One after each meal, or three a day. Electricity (galvanism) to spine. Good food, nutrient qualities, and ease of digestion to be considered.

Or again: Adopt such treatment as will increase the tone of the stomach, improve digestion, promote assimilation, and thus secure good blood, meet the wants of an impoverished spine and nervous system, secure rest and relieve pain. In the above nothing has been taken note of directly pertaining to the condition of the womb. In some cases some form of alterative may be needed; abdominal support, massage, stimulants, bitter tonics, etc. The above coupled with such hygienic measures as are called for, in dress and local sur-

roundings, and the freeing the mind from the depressing influences will do much to build up and invigorate the enfeebled system and thereby give better tone to the uterine organs as well as to the nutritive system. While in the general or constitutional treatment, regard has mainly to be had to the condition of the system in a general way; in the local treatment we enter another field, one where we must determine exactly what we have to treat and what there is to immediately complicate the case.

Local treatment.—As an examination with a speculum is necessary to ascertain the exact condition of the parts, so is the instrument necessary in order to apply treatment. The natural aversion to an instrumental examination by most females, and especially the younger ones, is bereft of most of its fear if they can be convinced of two things: that they will not be needlessly exposed nor hurt. And a digital examination should always enable the physician to know whether an instrument could be used without severe pain or not. If not, then the patient should be directed to use water just as hot as she could bear, with a syringe, several times a day for two or three days before making an examination. I have made examinations where it was necessary to use cocaine solution before an instrument could be introduced. These precautions will well repay the practitioner. After the instrument has been introduced, and the blades moderately expanded, with the cervix brought fully in view, carefully remove the secretions from the vagina and os—remembering that diagnosis and treatment are intimately associated. If there is but little secretion in the vagina and around the cervix, with a normal condition as to size and form of the cervix—with the usual plug of glairy mucus hanging from the os, the case is probably without complications and will readily yield to treatment. Remove the mucus with pleget of cotton or rubber dressing probe or with a long nozzled hard rubber syringe, by suction. Be very careful about the use of water to wash this mucus away, as water might be thus forced through the fallopian tubes and cause dangerous prostration. After all mucus and secretions have been removed I am in the habit of using a cone of my own preparation, composed as follows:

℞.	Calomel,	ʒ iij
	Iodoform,	ʒ i
	Ox. zinc,	ʒij
	Sal. ext. belladonna,	ʒj
	Pow'd gum acacia,	ʒj
	Aqua qs.	

M. Ft. cones No. 12.

These when placed in water for a few minutes are sufficiently elastic to yield to a slight flexion or to follow the canal without injury to the delicate and hypersensitive tissues. This is maintained in position by absorbent cotton, or antiseptic wool saturated with boroglyceride or carbolated glycerine. The patient is instructed to allow this dressing to remain until the next morning, then to remove it and use the syringe with water as hot as can be borne with comfort. The ladies' syringe to be preferred.

This treatment to be repeated once in four or five days, and not to be begun until three or four days after menstrual period ends and the same interval to be observed in approaching the period. If the cervix is found puffy, enlarged and highly sensitive, the entire infravaginal cervix may be penciled over with iodized phenol or the dark pinus canadensis (Kennedy's). If much sensitiveness, is manifest rest in horizontal position is advised, and irrigation with hot water is ordered once or twice each day. Where the womb is pressed low by superincumbent viscera, a proper abdominal support is advised, and the patient is directed to assume the knee-chest position for a few minutes when ready to lie down for the night. The new treatment of gonorrhœa opens a new thought in the treatment of endocervicitis, and one from which much good may be reasonably expected—that is the packing the cervical canal with dry powdered agents, as bismuth, boracic acid, iodoform, calomel, or other alteratives or astringents. The various agents to be properly reduced with starch or other neutral substances. From the valuable results claimed for Resorcin in various cutaneous and ulcerative affections, and its ready disinfectant properties, I would expect some very valuable effects from its use in ulceration of the cervix and from

glandular involvement of its canal. Galvanic and Faradic currents properly applied are useful in some cases. Also the scarification of the cervix when much inflammation and induration exists. Where extensive lacerations exist, Emmet's or some other form of operation may be performed after due attention has been given to the diseased tissues and glands. With the less grave cases, where there is but little eversion, I am inclined to agree with Hœgarath, that it is a question as to its pathological influence and the operation is of doubtful propriety.

Where the case is one of corporeal, as well as cervical endometritis some distinct measures have to be adopted. This extension to the corporeal endometrium may be of any grade from the lightest form of exaggeration of the secretory function of the utricular gland, causing uterine leucorrhœa, through all shades of severity and epithelial destruction to that of complete exfoliation of the lining membrane, and the destruction of the glandular structure and development of small cysts, by closure of duct orifices. In addition to the constitutional measures directed heretofore, we may add such agents as will help to reduce the irritation and inflammation of the mucous structures and other tissues that are more frequently involved than in cervical disease alone. Locally several plans have been adopted: The applications of solids; applications of fluids; injections and the use of ointments. The applications of solids is attended with too many dangers to ever become popular. The use of fluid agents with the silver or rubber dressing probe certainly meets all the requirements and is not attended with the dangers of either solids or the injection of fluids—the latter being the most dangerous of any of the different forms of treatment. If to be applied at all, it should be with the Molesworth syringe or some form of double canula, allowing free return of fluid. Ointments are not satisfactory and seldom used. Where this condition exists, as discovered, or suspicions confirmed, by the ease of passing the cotton wrapped probe or application through the os internum and into the womb, an effort should be made to remove gently all secretions and then pass through cervical canal, patulous or dilated, the cotton wrapped rubber, the cotton saturated with such agents as it is desired to use: such as solutions of silver, zinc, copper, iron, chromic acid, comp. tr. iodine, pinus can. or hydrastis. Where a chronic metritis, hyperplasia or subinvolution exist as complications of the cervical, they should receive proper attention in connection with the treatment of the other conditions.

There is one agent that I cannot pass unnoticed at this place, viz. the curette. There may be a class of cases of corporeal or general metritis where its judicious use would result in good, but in the majority of cases it is used because the doctor cannot think of anything else to do for his case. But let the local treatment be with the curette or without it, with solid caustics or liquid astringents, with mild local alteratives or gentle emolients, unless the constitutional conditions are carefully looked after, and every vice and defect remedied, failure will be oftener the reward of our labor than otherwise. And every physician, after making himself perfectly familiar with all the minutia of diagnosis and treatment, should demand perfect advisory control of his case before undertaking its treatment, to make success assured.

Atresia Hymenalis et Vaginas.

Read before the South Kansas Medical Society, Newton, Kansas, November 11, 1889.

BY CHARLES W. ADAMS, A. M., M.D., PROFESSOR OF DISEASES OF WOMEN AND CHILDREN, UNIVERSITY MEDICAL COLLEGE, KANSAS CITY, MO.

The cases which we meet, that fall under the head of the gynatresiæ, may practically be divided into the following classes.

Those in which we have an arrest in development either in a whole or in a part of the genital tract.

Those in which the genital organs are fully developed, but where there has been an arrest in their growth.

Those in which, either before or after coming to maturity, there has been an obliteration

or a loss of the whole or a part of the genital organs either from disease or injury.

Cases which fall under the first class can only be explained by a reference to the course of development during intra-uterine life. For the second class intra-uterine development may be perfect, but for some reason the further change or growth which occurs at puberty does not take place. Under these conditions the organs are infantile and incapable of performing their normal function. The first and second classes may be combined in various degrees.

For the third class if during childhood as the result of scarlatina, measles, diphtheria, typhoid fever or injuries, adhesive inflammation occur, we have an atresia of the vagina or stenosis of the os uteri. This may entirely escape observation, until attention is called to this condition at the age of puberty. After puberty the same result may be set up by injuries, which may be so extensive as even to cause the entire loss of the generative organs.

In a majority of cases attention is first called to a generative defect by various occuring menstrual mollimina without the appearance of blood and the presence of an increasing abdominal tumor, with pain. This pain during the time of menstruation has the character of a most violent uterine colic. If the defect be of the hymen alone or even the vagina, inspection and palpation will easily determine the cause of the trouble. If the trouble lie in the uterus, diagnosis will be more difficult. However by combined examination and a careful method of exclusion certainty may soon be reached. In cases admitting of this, an exploratory puncture with a fine aspirating needle has been advised as perfectly safe. The presence of the thick, tenacious black blood will render the diagnosis certain.

In defects involving the hymen and lower end of the vagina, simple puncture with a large trochar to allow the retained fluid to gradually flow out, care being taken to prevent septic decomposition, will suffice. Subsequent enlargement of the opening may be made. When however the atresia of the vagina is complete, a transverse incision is first made between the rectum and urethra, then with the finger we slowly burrow upward, being careful with a finger in the rectum and sound in the bladder to guard these organs from injury. If it be impossible to reach the blood cysts in this manner, it is recommended that the urethra should be dilated, and an opening made through the bladder for the present escape of the menstrual fluids. The complete evacuation of the fluid is in most cases impossible, on account of the viscid character of the blood. I believe therefore it is a good rule, to allow of the gradual emptying of the fluid, striving by repeated injections of carbolized water to keep the parts aseptic. The dangers to be apprehended, are sloughing of the blood cyst, rupture of a tube into the abdominal cavity, or septic infection. The last, unless the greatest precaution be taken is apt to occur, and renders the operation one justly to be dreaded. The organs are in the highest degree subject to metamorphic changes, hence every aseptic precaution should be taken before, during and after the operation. Pressure on the abdomen after the puncture should be carefully exercised or even not allowed, and every violent action on the part of the patient which may lead to rupture of the tube, should be guarded against.

The following cases which have come under my observation may serve better to illustrate the subject:

CASE I.—Atresia hymenalis with normal external formation, internally two vaginal and two uterine canals, (bilocularity.)

Mary W—, came to me for treatment October 20, 1887. The patient was fifteen years old, was well developed and in good general health. Examination showed the external genitals well formed but there was a complete closure of the vaginal orifice. Between the labia was a longitudinal depression in the center, with a bulging out of the closed membrane on either side. Palpation of these prominences and rectal examination gave a distinct sense of fluctuation. Palpation over the abdomen, showed the uterus to be enlarged as if at about the seventh month of pregnancy, with a smooth normal round feeling to the hand. The history given was that the patient began to have symptoms pointing to menstruation at the age of fourteen and that these had been regular and monthly up to the date of being seen. The family physi-

cian, Dr. C. Kellar, of Santa Fe, Kansas, had been consulted in regard to these, as well as the non-appearance of the menstrual flow. His examination disclosed the condition of the genital organs, with the gradually increasing tumor in the abdomen; operation was advised. Under the influence of chloroform a trochar was passed through one protuberance diagonally through the central depression into the other protuberance. About twenty ounces of a thick, tenacious dark fluid was slowly exuded. The opening was carefully enlarged and the patient was put to bed, absolute quiet being enjoined. The uterus gradually emptied itself, without marked pain, until it could not readily be felt above the pubes. The operation as well as the after treatment was strictly aseptic. Hot bi-chloride injections at intervals of four hours, with carbolized compresses of cotton to the external parts. The temperature the day after the operation rose to 100°, but fell to normal on the third and remained at normal on the fourth and fifth day. The injecting fluid came away clear on the second day. The appetite was good, the bowels regular, no pain and every symptom indicated a recovery. On the morning of the sixth day, the patient still confined in bed, a chill occurred followed by fever, which continued until the tenth day, when death closed the scene. The symptoms and cause of the fever were those of septicæmia.

Post mortem examination disclosed the abdominal cavity filled with pus. The uterus, fallopian tubes and vagina were normal in their external appearance. On being laid open it was found that there were two uterine cavities communicating each with their respective fallopian tube and two vaginal tracts. The longitudinal central depression spoken of before was caused by the attachment of the septum to the closed hymen. The diagonal puncture had emptied both cavities; no pus was found in the entire genital tract, that being remarkably free from any sign of inflammatory action. As was afterwards ascertained infection was carried to this patient by a vaginal tube, which was used in another patient suffering from sepsis, the result of an abortion.

CASE II.—Atresia of the vagina with absence of the perineum and lower half of the vagina. Dora S—, aged 16, came under observation June 2, 1888. The patient had been treated for a year by various physicians for violent attacks of uterine colic occurring at menstrual epochs. She was anæmic and poorly nourished. Examination disclosed a central tumor within the abdomen, above the pelvic brim, which was evidently the uterus. There was an entire absence of the perineal body, the anal orifice being trumpet shaped, its anterior wall sloping upward to the pubes from a point at about the apex of the perineal body. There was a bulging down of this wall within the rectum giving a distinct feel of fluctuation. By an exploratory puncture through this wall, about one ounce of a thick black fluid was withdrawn. It being near the time of her supposed menstruation, operation was deferred for the time. At 7 P. M. on the fourth day of coming under observation, the patient having been up and about during the day, violent attacks of uterine colic set up. Sulphate morphiæ by hypodermic injection in ½-grain doses was used with but little relief. At midnight the pain suddenly ceased, and the attending nurses' attention was called to the collapsed condition of the patient. When I saw the patient an hour later, I found both labia were enormously distended and black, apparently with infiltrated blood, the infiltration extending up over the pubes upon the abdominal wall. An incision in both labia withdrew a large quantity of fluid similar to retained menstrual fluid. Consultation determined that nothing was to be gained by operative interference. The patient was in a state of profound collapse, from which it was impossible to arouse her. Death occurred in a few hours after being seen. No post mortem was obtained. The thing to be regretted in this case is that operation was not immediately attempted, when the nature of the case was rendered certain by aspiration. There should have been no delay on account of a coming menstruation.

CASE III.—Atresia vagina with infantile uterus.

Kate W—, a well formed and well nourished young woman, aged 26, was seen with Dr. Eggers, of Kansas City, October 10, 1888, in

regard to her failure to menstruate and a deformity of the genital tract. Inspection showed no vaginal opening whatsoever. Examination by the rectum and bladder disclosed a line of dense tissue, between the rectum and the urethra and bladder, with a hard round body high up which was determined to be the uterus. There had been since the age of puberty definite monthly symptoms pointing to a menstrual molimen, but so far as any objective symptom (that is, accumulation of blood) was concerned, no operation was necessitated. The patient, feeling that she was not as other women, insisted upon surgical alleviation. A transverse incision was made in the dense septum, between the meatus urinarius and the anal orifice, and with the finger guarded from the rectum and bladder, an opening was burrowed up to the body which had previously been felt. This was ascertained to be the uterus, but extremely small, though perfect in shape as far as could be determined. A closed glass vaginal speculum was left in the opening. The patient rallied from the operation with no unfavorable symptoms. The case passed from observation wearing the glass plug, but it has since been learned that from disinclination on the part of the patient to persist in treatment, an opening only two inches in depth persists, the upper extremity being closed. The menstrual molimena have been gradually losing their force and frequency. In this case the ovaries evidently gave the force exciting to menstruation, but the uterus being undeveloped there was no exudation of blood.

CASE IV.—Atresia of the upper third of the vagina, the result of labor.

Mrs H—, age 27, married, came under observation April 4, 1888, for a condition of the vagina, which dated back to a labor six months previous to being seen. The anterior wall of the vagina had been torn through at about the base of the bladder, allowing this to fall down completely obliterating the anterior and posterior cul de sacs of the vagina. In fact, the whole upper portion of the vagina was filled with cicatricial tissue, completely concealing the uterus. At one side a minute opening was found leading by a tortuous canal to the os, through which menstruation was performed. The vaginal tract led directly into the bladder, the posterior wall sloping upward so that the bladder was a cul de sac for the vagina. The ureters had fortunately escaped injury. With the vesico vaginal fistula or opening, we have nothing to do, although no operative procedure could be attempted for its cure without at first getting rid of the partial atresia vagina. After repeated efforts and persistent treatment, the upper vaginal vault was completely opened and the uterus again left free in the vagina. Nothing especial belongs to this case, save that it is illustrative of a class of atresiæs which result from injury during labor.

CASE V.—Atresia of the vagina with loss of the entire generative organs, as the result of injuries sustained during labor.

Mrs. Nettie B—, age 21, married, came under observation February 18, 1886. The patient was anæmic in appearance and gave evidence of having passed through a severe course of sickness. The history obtained was that four months previously she had been delivered instrumentally of a child. Her recovery was extremely slow. Vaginal injections were used after labor took place. About twelve days after delivery a mass of tissue came from the vagina, about the size of four fingers including their bases. This mass, from the history and description, was neither blood nor placental tissue; but confirmation of this was wanting since it had not been submitted to the examination of any physician. Between the second and third week after delivery, it was observed that the vagina injection was given each time with increasing difficulty. I do not know as to whether the attending physician was consulted in regard to this. However, according to the history given, the opening gradually decreased in depth, until finally, complete occlusion of the vagina resulted. It was for this condition that counsel was sought. Inspection showed that the vaginal orifice between the labia was closed completely, a diagonal line of cicatricial tissue running from the right labium at about its middle, upward to the left. Bi-manual examination disclosed a dense thickened layer of tissue between the rectum behind and the urethra and bladder in front, extending upward to a small accumula-

tion or body about three inches above the closed vaginal orifice, which was diagnosed to be the cervix of the uterus. Through the abdominal wall nothing could be felt. I confess that the diagnosis was not plain, but taking the history in consideration, it was decided to make an attempt to open the vaginal canal. No light was thrown on this case by any menstrual molimina, nor did we expect to find what was afterward disclosed. An incision was made with a knife along the line of cicatrix, and with the forefinger we carefully burrowed through the tissue, between the rectum and the urethra and bladder. The finger worked upward easily, until the body mentioned as the supposed cervix was reached, when the finger was forced upward and a short distance above broke through into space. Going back to the point of resistance, the opening was worked below the resisting body and in a short distance again broke into space as before. The resisting body was found to be a mass of the cicatricial tissue. With the finger of one hand in the rectum, and the forefinger of the other hand passed through the dilated urethra into the bladder and the fingers of an assistant meeting these through the abdominal wall, a careful exploration was made for the missing uterus, fallopian tubes and ovaries; but nothing could be found; no uterus, no fallopian tubes, no ovaries. A Linus closed glass vaginal speculum or plug, three inches in length by one and one-half in diameter was inserted along the tract of the lower opening and the patient put in bed on appropriate treatment. No unfavorable reaction occurred, the patient being up and ready to return home by the 10th day. On account of the profuse discharge of pus from the opening, a gutta percha plug with holes bored in its closed extremity to allow of drainage, was substituted in place of the glass instrument. The patient was instructed to retain the plug constantly in situ, and only to remove it morning and evening when a disinfectant wash was used for cleansing purposes. Six months after the operation, the patient was seen again. The opening was patulous, being covered for an inch and a half over its lower extremity with mucous membrane; the remaining portion being still denuded and secreting pus. The plug was still worn, giving but little discomfort. Her general health was good, she being able to perform all the duties of a farmer's housewife. During the two weeks when she was under observation at this time, small portions of skin were imbedded in the denuded surface. A year after the operation, removing to the vicinity of Kansas City, she was seen again, when it was found that the entire opening was covered with a membrane, with the exception of a spot at the extreme point of the cul de sac, about the size of a silver dime. By dusting this with iodoform and packing the cavity with cotton, a complete covering was obtained at the end of a few treatments. The opening when seen last, two months ago, was between two and one-half to three inches in depth, of sufficient caliber to admit a small vaginal speculum and covered by a pink membrane not unlike a normal vaginal membrane. No speculum or cotton plug had been worn for a year past. By careful inquiry no evidence of a menstrual molimen has at any time occurred since her delivery in 1885. The opening on a separation of the labii, looks normal and evidently subserves a useful purpose. Sexual aptitude, however, is to some extent lost. The conclusion in this case, which, perhaps, is a unique one, is that the mass of tissue which came away at about the 12th day after delivery, was the uterus which was sloughed off on account of death occurring in it as the result of injuries sustained at the time of delivery. That the patient was delivered of a child at the time stated, is corroborated by a letter which I have in my possession, from Dr. E. E. Hamilton, of Wichita, who was called in consultation at the time of delivery. That the internal organs of generation were not present at the time of operation is evidenced by the thorough search of the pelvic cavity, as well as the subsequent absence of symptoms pointing to their presence.

From these cases it is not difficult to draw the following conclusions:

1. The necessity of operative interference in all cases where there is an establishment of the menstrual function and an accumulation of blood.

2. The great danger of septic infection, even more so than in other operations. Hence here

if nowhere else, the necessity of every aseptic precaution.

3. The possibilities of success, under circumstances in which it might seem impossible.

4. The necessity of persistence in treatment, both on the part of patient and physician.

Intestinal Obstructions.

Read before the Northeast Kansas Medical Society, at Horton, December 3, 1889.

BY L. REYNOLDS, M. D., OF HORTON.

This term comprehends conditions widely different in their pathology.

I shall not attempt to enumerate all of the different pathological conditions that may directly or indirectly interfere with intestinal calibre.

As intussusception is the most frequent and fatal and consequently of greatest interest to the general practitioner, this paper will be confined to the consideration of this form of obstruction.

The small intestine is a cone about twenty feet long of which the upper end forms the base and the lower the apex. The same is true of the large bowel, except that it is only about five feet long.

The majority of cases occur under the age of twelve, and one-fourth of all cases occur between the ages of three and fifteen months.

The frequent occurrence of this form of obstruction in infancy is thought to be due to greater frequency of intestinal irregularities in the intestinal movements than in older children. Also to the thinness of the intestinal wall due to the lack of development in the mucous and muscular coats and connective tissue. The intestinal supports are also more relaxed,and the larger bowel in which this form of obstruction usually occurs, is crowded into a smaller proportionate space than in older subjects, thus throwing the gut into closer folds.

Intussusception may be acute or chronic and involve any part of the intestinal canal.

The form with sudden and violent onset accompanied by great suffering, and which may, if not relieved, lead to death in a few hours or, at most, in a few days, is called acute.

While the form which gradually develops, is unaccompanied by sudden and great depression of the vital forces, and which leaves the intestine pervious, but of diminished calibre, may exist for several months but usually produces death in time, is called chronic.

The following case which recently fell under my notice, illustrates the chronic form:

Patient a little girl aged twelve, had been sick about two months when I saw her, and was greatly emaciated. In fact I regarded her as the poorest person I had ever seen alive.

As nearly as I could get the history of her illness, it began with slight indisposition, poor appetite, didn't want to go to school, occasionally vomited, was without fæcal movement for two weeks and but little for four weeks. No medical aid was sought during the first two weeks of her sickness.

Her attending physician first found the abdomen considerably distended, but, as I understood could find no tumor other than the general abdominal distension. Later on, perhaps two weeks later, an injection of soap suds, one-half gallon was given and retained twenty-six hours. Following the injection the little girl got easy and slept well without an anodyne.

After the lapse of the twenty-six hours her bowels began to move and a tendency to diarrhœa developed and continued until the child's death three or four weeks later.

Immediately after the action of the enema a tumor a little larger than an adult kidney, but of about the same outline, could be felt in the upper portion of the right lumbar region. Subsequently the same tumor was found in all of the abdominal regions whereever gravity happened to place it.

It was pretty firm but elastic, could be rolled about in the abdominal cavity with ease, and usually without much pain to the patient. All motions of the bowels contained pus and most of them both blood and pus. About ten days before death pus began to discharge by the vagina. We were unable to make a positive diagnosis and as the progress of the case indicated a speedy, fatal termination, made a

request for a post mortem examination in case dissolution occurred.

Autopsy made in the presence of Drs. Fisher, Stivers and Hackadorn, revealed an enlargement in the ascending colon produced by an invagination of ilium and ileocæcal valve, drawing after it the cæcum.

Although the adhesions were slight the intussusception had evidently existed a number of weeks as the bowel had become so adjusted to its new relation that it required considerable force to dislodge the invaginated portion. The valve formed the apex of the intussusception and a perforation existed near its base which ended in a fistula opening into the vagina. The mesentery of the intussusception was tightly drawn and caused flexion of the invaginated portion towards mesenteric side of its receiver or the intussuscepion thus increasing the tendency to complete occlusion. The junction of the large and small bowels is the favorite seat of acute intestinal pathology. The two most common forms of invagination involving this part, are prolapse of ilium through ileocæcal valve and inversion of the cæcum into ascending colon.

Occasionally the cæcum is primarily inverted and invaginated and descending along the colon, it draws after it the ilium which sustains its natural relation to the ileocæcal valve.

Usually as the intestine becomes invaginated its mesentery or mesocolon is also invaginated and its veins compressed, causing venous stasis and the condition of the incarcerated mass becomes that of intense congestion which may be followed by gangrene. With reference to the causation of gangrene, Dr. Senn asserts, and apparently proves in his experiments on animals, that it is due to venous stasis rather than to an interruption of the arterial supply as formerly taught.

In infants, after a few hours, the capillaries become so distended in the invaginated portion that they generally give way and the blood appears externally in the way of scanty motions from the bowels.

Generally the portion of the intussusception forming the exterior of the invaginated mass is much drawn together or contracted into folds.

The mesentery necessarily forms a part of the intussusception and is more or less stretched and compressed, venous return is impeded or interrupted, swelling ensues, the invaginated portion is infiltrated with bloody serum, an acute catarrh of its mucous membrane is established, the peritoneum becomes intensely hyperæmic and an abundant plastic exudation is poured out, glueing together the contiguous portions of its surface.

These are the usual steps of acute intussusception. The compression of the mesenteric vessels may cause necrosis of the incarcerated bowel which may slough and restore continuity, but there are various dangers attending this process that must be borne in mind, such as sloughing with insufficient adhesion of the remaining opposing surface allowing an opening into the peritoneal cavity as occurred in the case above reported, and if this does not occur the ulceration accompanying the slough may leave enough cicatricial tissue to seriously abridge the intestinal canal.

It has been experimentally demonstrated on animals that a contraction equal to one-half of the intestinal calibre is not incompatible with life and health if it involve only the convex surface of the bowel. Any marked contraction of its concave or mesenteric border seriously interferes with the nutrition of that part of the intestine. The severity of the symptoms is in proportion to the amount of constriction of intestinal calibre and interruption of circulation in the vaginated portion.

Duration and location of the intussusception also influence the symptoms.

A symptom which is always present and of great importance is pain. This is very severe in most acute cases and a source of considerable exhaustion, is felt principally at first about the umbilicus but spreads as peritonitis develops.

One or two natural passages may occur after the intestinal canal is completely occluded. Tenderness to pressure, gaseous distension of bowels and vomiting are common to nearly all forms of intestinal obstruction.

The point of tenderness may, at first, indicate the seat of obstruction, but later peritonitis is apt to develop and extend the region of tenderness.

The above symptoms may be so intense as

to induce collapse after which pain and tenderness cease.

If the symptoms have occurred suddenly and are very acute and peritonitis is present, a firm and complete obstruction is probable.

A finger passed into the rectum may come in contact with the lower end of the intussusception, or the invaginated bowel may protrude from the anus.

TREATMENT.

The first thing to do is to determine whether the incarceration is in the large or small intestine.

Wm. Treaves says this can usually be determined by noticing the condition of the cæcum. If it be distended the large bowel is the seat of obstruction and can be found by following the course of the colon. If on the other hand, the cæcum be found empty, the occlusion must be in the small bowel.

I want to add that the relation of the parts may be, and frequently are, so altered as to be very confusing.

All intussusceptions that concern us occur from above downward, and the indication is to counteract the inversion from below. The methods of doing this are injections of liquids and gases with supplementary aids and direct manipulation through an incision in the abdominal walls. In addition to this indication, there is another adhered too by some practitioners, that of giving opium and awaiting the result.

Dr. Senn has shown that invagination artificially produced in animals is frequently spontaneously reduced, even after suturing the neck of the intussusception and I have no doubt spontaneous reduction frequently occurs in the human subject before a diagnosis is made.

This experiment shows that all cases, if experiments on animals prove true, of the human subject, are not necessarily fatal when left to nature.

The intussusception, to be susceptible of relief by injections of liquids, must be below the ileocælic junction or above an incompetent ileocæcal valve. We have seen that an incarceration involving the relations of the valve may render it incompetent and thus permit liquids safely to pass it.

In order to succeed with liquid injection considerable force is usually necessary and any force sufficient to reduce the invagination, in some cases, may rupture the bowel.

To apply this pressure efficiently and safely the surgeon should have an approximate idea of the amount of force he is applying and the amount the bowels will stand. The intelligent physician can have some idea of the amount of pressure to apply by the extent of abdominal distention, and when the principle of the Davidson syringe is used this is the only guide.

It has been determined by experiment that fifteen pounds to the square inch is all the force that can be safely applied and this only in adults. In infants the pressure should not exceed six or eight pounds to the square inch.

To approximate the force used by the fountain syringe it is only necessary to remember that the atmospheric pressure which at the sea level is nearly fifteen pounds to the square inch, sustains a column of water nearly thirty-four feet high and will equal about one-half pound to the foot.

To apply the amount of pressure that the adult bowel will stand, a column of thirty-feet of water taking its base in the intestine may be used or twelve to sixteen feet in case of a child.

A rubber tube the necessary length may be secured and attached to the nozzle of a Davidson syringe. The long vaginal nozzle should be used. The addition of a funnel and vessel of warm water will constitute the necessary apparatus. The nozzle should be well inserted into the rectum. A shoulder should be made near its base to press against the sphincter to retain the liquid. This can be made by the use of a narrow roller bandage tightly wrapped. An anæsthetic should be used to enable the patient to bear the pain incident to the abdominal distention as well as to relax the abdominal walls.

The nozzle should be inserted by the surgeon and retained by one hand, while he uses the other in gently kneading the abdomen. An assistant should slowly add water to the tube as he elevates its free end keeping it well filled.

If it be the case of a child the elevation

should not exceed, as a rule, twelve or sixteen feet. Plenty of time should be taken in adding pressure to give the tissues time to expand.

If hydrostatic pressure fails after a careful trial, gaseous injection may be tried by attaching a pair of bellows to a glyster pipe, or inserting the nozzle of a small pair into the anus. This method can also be used by the insertion of a nozzle connected by a rubber tube to an inverted bottle whose contents furnish gas.

The method of gaseous injection has the advantage of adaptability to any part of the intestinal canal, as its passage is not obstructed by the ileocæcal valve, but has the disadvantage of your not knowing how much force you are applying.

The longer the existence of an invagination the less the chances for relief by either of these methods on account, in most cases of the opposing serous surfaces. These may form so strongly in twenty-four to forty-eight hours as to endanger the integrity of the intestine before they will give way.

In applying these methods an inclined position of the patient, head downward, will be found advantageous by favoring retention of liquid and reduction of the invagination.

Judging from the findings of the autopsy in the case above reported, liquid injections might have succeeded in overcoming the invagination some considerable time after its occurrence, perhaps, three or four weeks.

If the incarceration be in the small intestine and the ileocæcal valve competent the injection of liquid should not be thought of as any pressure sufficient to overcome it, always causes multiple longitudinal la cerations of the peritoneum with but one result—death to the animal.

Those who depend upon opium and quiet entertain but one hope, I believe, and that is, that the incarcerated portion may slough out and thus restore the intestinal calibre. This is fraught with two principal dangers. First, the sloughing may cause perforation of the bowels, and second, cicatrization may so abridge the intestinal diameter as to interfere with nutrition and result in death by exhaustion or starvation.

If the above means have been faithfully tried without success, I feel like urging a resort to the method of direct manipulation through an incision in the abdominal walls. The average regular physician is fast reaching the position where he will not hesitate to open the abdominal cavity, where it is clearly necessary.

If I should allow a case to die without an attempt to relieve him by laparotomy, I should feel like I had fallen short of my duty. A desperate condition warrants a desperate remedy.

A New Law.

EVERY CASE OF TYPHOID FEVER MUST BE REPORTED TO THE HEALTH OFFICER.

Typhoid fever is a disease which the State Board of Health has declared to be "dangerous to the public health," and as such it comes under the law requiring physicians to report to the health officials. Any physician who shall neglect to immediately give such notice, "shall forfeit for each such offense a sum of not less than fifty nor more than one hundred dollars." And since October 1st, "*any householder* who shall refuse or willfully neglect immediately to give such notice, shall be deemed guilty of a misdemeanor, and liable to a fine of one hundred dollars, or in default of payment thereof may be punished by imprisonment in the county jail not exceeding ninety days."

It seems important that the public generally shall understand that this new law applies to scarlet fever, diphtheria, small-pox, and all diseases dangerous to public health, as well as to typhoid fever. At this season, typhoid is most prevalent, and is especially dangerous in times of drouth; therefore the safety of the people will be greatly promoted by having every case promptly reported to the Health Officer, who (Sec. 1, Art. 137, Laws of 1888) is required to promptly attend to the restriction of the disease. The new law makes it a misdemeanor, punishable by fine or imprisonment, for the Health Officer to knowingly violate that section of the enactment, or for any person to violate the orders of the Health Officer made in accordance with that section. The actual penalty, however, which is incurred, is—*death!* And about one thousand people are lost in this State annually from typhoid fever alone. The saving of a large proportion of these lives is the real reason for the effort, in which it is hoped all people will join.—*The Michigan Medical Age.*

SOCIETY PROCEEDINGS.

South Kansas Medical Society.

[These proceedings were in type for last issue, but by a press of advertising matter they were unavoidably crowded out.]—PRINTER.

The South Kansas Medical Society held its thirtieth semi-annual session in the city of Newton, November 11th, 1889, Dr. C. E. McAdams, vice-president, in the chair, Dr. W. K. Harris at secretary's desk. Routine business disposed of at morning session.

Board of censors—Drs. Vannuys, Klippel and Axtell. Board reported favorably on admission of Drs. V. E. Lawrence of Halstead, and Jeffrey Martin of Marion.

Election of officers for ensuing year resulted in Dr. C. E. McAdams, president; Dr. J. W. McCracken, first vice-president; Dr. Whittecar, second vice.president; Dr. Harris, secretary; Dr. C. C. Furley, treasurer.

Before adjourning morning session, a motion was carried appointing a committee of five to suggest changes or revision of Constitution and By-laws, and report them at 1:30 o'clock p. m.

Chair appointed on committee, Drs. Klippel, Furley, Vannuys, Hamilton and Harris.

AFTERNOON SESSION.

Committee reported and made the following suggestions as to change: That Article 4 of Constitution be amended so as to read, "That the stated meetings of this society shall be held the first Tuesday in May and third Tuesday in November of each year, and shall be at such places as a majority vote shall determine." And further recommend that Article 9 shall be amended by striking out the words "fifty cents" and inserting "one dollar." Also recommend that five hundred copies of Constitution and By-laws be printed and each member of society be furnished a copy.

Signed J. D. VANNUYS,
C. KLIPPEL,
C. C. FURLEY,
W. K. HARRIS.

Reading of papers first on programme.

Dr. McCracken, of Sterling, read a paper on "Chronic Cervical Endometritis."

Discussion opened by Dr. Klippel. Had been using creolin in from one-third to full strength in these cases with good results.

Dr. Oldham thought ground had been fully covered and endorsed the paper.

Dr. Lawrence wanted to know how he treated the accompanying vertigo. Had treated a case not long since, with good results except as to that.

Dr. Axtell thought it the most common disease of woman we are called upon to treat. Thinks laceration of cervix a prolific cause. Treat laceration and cure will result of itself in most cases.

Dr. Martin suggested hot water as a means of preparing patient for treatment, and in conjunction with white pinus, a very good remedy. Thinks laceration should also be treated.

Dr. Adams.—The paper is a classical one, I have had no success with any one line of treatment. Social laws, customs and surroundings are against us in the treatment of such cases. Cases of laceration which had been cured by resorcin justified the treatment.

Discussion closed by Dr. McCracken. This disease might occur if os uteri had been extirpated years before. One must be on the watch and guard against cardiac trouble, menta worry, etc. We do not examine close enough in the start. We should inculcate caution and study closely all cases. If laceration of the cervix exists, operate. The "Lady's syringe, from convenience for use, is a valuable aid to treatment, and use hot water. When I say hot water I mean *hot* water. I would not treat a case unless I could have complete control of patient as to dress, habits, sexual congress, etc.

Dr. McClintock, of Topeka, read a paper on "Orthopædic Surgery," and presented a case under treatment for talipes equino-varus, caused, he thought, by pre-natal spina bi-fida. Also demonstrated on the patient the method of applying plaster Paris bandage.

Dr. Coleman—I believe such cases are hereditary. Cited a case where a pregnant woman from seeing a case had forebodings, and at term brought forth a child worse deformed than the original case.

Dr. Buck—Would not relapse have been prevented by resorting to tenotomy in the beginning?

Dr. Cordier.—How long had electricity been tried in this case to overcome paralysis and stimulate the growth of muscles in calf of leg?

Discussion closed by Dr. McClintock. Better treat varus first, then perform tenotomy.

Dr. McClintock in closing the discussion said: Maternal impressions do have a determining influence in some cases. In answer to Dr. Buck, would say tenotomy had been made when the child was four months old, after first having treated the varus. The plantar fascia should be cut if extremely resistant. Good results have been obtained by the use of electricity in paralytic atrophy of the muscles.

When it is thought a cure has been affected, a retentive dressing should be used for one or two years as a precautionary measure.

In answer to Dr. Cordier who asked regarding contractured tendons, I would say they exist only in the mind of one man. There is no such thing as contractured tendons.

Dr. Harris.—There are contractured tendons. I have found them too plain to doubt.

Dr. Klippel.—How soon would you begin treatment? Is nine weeks too soon?

Dr. McClintock—No, they are never too young, but be careful of excoriations.

Dr. Adams read paper on the malformations of the uterus and vagina.

Dr. Klippel—I have never seen snch cases. Dr. Richmond, of St. Joseph, Mo., has related a case treated with a glass plug.

Dr. Hamilton—The case detailed by Dr. Adams I saw in consultation in 1885. The head was above the superior strait. I applied the forceps and had the doctor examine to see if they were right before making traction. The head was brought down and a mass of foul debris came away in a gush, The delivery was completed by removing the placenta, to which I called the physician's attention that no mistake might be made as to its removal.

Dr. Fabrique reported a case of imperforate hymen with retained menstrual fluid. Rupture of the hymen, permitting the fluid to escape, completed a cure.

Another case in which the girl menstruated one year. Menstruation ceased and the family brought the girl to him believing she was pregnant. The walls of the vagina were agglutinated but easily separated by the finger, when a tarry fluid drained away and the pregnancy vanished Bi-chloride, 1 to 5000 is the best antiseptic wash.

The death rate in these cases is too great considering the antiseptic precautions and hence I believe there is some other cause for death than septicæmia.

Dr. Martin—In these cases the uterus should be washed out to prevent septic poisoning.

Dr Adams—Scarlatina or diphtheria may cause atresia vagina. Had I another case to treat I would operate antiseptically, but I would not use a wash internally after operating. Apply externally an antiseptic dressing. Sepsis causes the sudden deaths. A small opening should be made in those cases, for I think it a dangerous operation. Laparotomy in the case I reported I think would have done no good. In one case there might have been a double uterus and emptying but one may have set up uneven contractions.

Dr. Buck moved that all papers read before the society or by title be referred to the committee on publication with instructions to have them published in the KANSAS MEDICAL JOURNAL by the consent of the writer

Dr. Harris read a paper on "Transition of Fevers in Southwest Kansas.

Dr. McCracken—Some eight or nine years ago met with such fevers. They puzzled me at first. Thought they were diseases of older countries. Drinking water people used was from open wells. Such fevers, doctors of that time called, as did army surgeons, typho-malarial. After a while I thought them typhoid. Did not use so much quinia as Dr. Harris. Spoke of a seminary at Pittsfield, Mass., where an outbreak of typhoid was traced to break in a sewer. Some forty cases resulted. Does not think it necessary to import it to have it here. Causes are local, but know not what they are.

Dr. Coleman came in contact with it some years ago. Lost five cases in one family. Physicians could not account for disease. Found as a cause the house was built on low ground, a hill rising up from it to a thicket, with stable and hog-pen between house and thicket. Thicket used for outhouse or privy,

all the water or flow coming from it to well on low ground. Spoke of typhoid cases in Newton, where only source of infection found was a well, the water of which was contaminated from privy vault.

Dr. Klippel—Winter of '85 was very dry, lots of hog cholera and a great deal of fever. Called it typhoid. Had seven autopsies, and in all found lesions of Peyers patches. Now as to conclusion, in 1881 less, and in 1888 still less. Believe decaying animal matter and excrementitious discharges can cause typhoid.

Dr. Martin—Think it now conceded no difference between typhoid and typho-malarial. Such cases are more prevalent in dry weather or years. Does not dread it any more than lung fever. Think the paper very good.

Dr. Fabrique—Know from autopsies we have typhoid,also fevers different from typhoid. I call them malarial fevers, if we know what malaria is. Pulse is different in typhoid. A man will come into your office with a temperature of one hundred and four or five degrees. It must be continued fever.

Dr. Martin—Should draw a line between typhoid and remittent tever. Quinine may do in one, treatment must be tentative in the other.

Dr. Oldham—Typical diseases as a rule are easily diagnosed. We have typhoid and some other fevers which I think are remitting. We find fevers taking symptoms of both. You find cases of temperature of one hundred and four or five that lapse into typhoid. Typhoid must have a specific course. Cited outbreak at Plymouth, Penn. There people, using separate wells had no typhoid, those using reservoir water had. Infection was traced to case up on mountain, whose dejecta being thrown out on ground, melting snow carried it to reservoir, hence the infection.

Dr. McAdams—There are two distinct fevers. One comes from decaying vegetation, algæ, and the other from some specific contagion.

Discussion closed by Dr. Harris, Our fevers are changing from intermittent and remittent to typhoid and relapsing. As to question, "How do you diagnose cases when first seeing them?" If patient has not been sick more than 24 to 36 hours, and find temperature of one hundred and three and a half ° or higher, tell them it will not be typhoid, or is not typhoid. A proper amount of quinine given would break a remittent fever. Eight or ten years ago, when I first advanced the ideas I do to-day, was told it was nonsense to talk of such being typhoid: no such fevers were here and could not come until imported. Find the profession coming round to my views. Do not think there are as many cases as laity are led to believe. In answer to Dr. Martin's question. "Have you ever given twenty grains of quinine at one dose, to a patient?" No; took one such myself fourteen years ago; never have tried it on any one since.

" Disease of Mastoid and its Treatment," by J. E. Minney, M. D., was last paper read. Owing to lateness of the hour, did not receive the discussion so interesting a paper should.

Auditing committee made a report approving the reports of Secretary and Treasurer.

Motion, Secretary's bill be allowed and order drawn on Treasurer for same.

Receipts of meeting, $4.50.

Society adjourned to partake of supper at Clark house, after which toasts were proposed and responded to by Drs. Furley, Minney, Foote and Buck.

Academy of Medicine and Surgery.

The academy of medicine and surgery met at their hall in regular monthly session, Tuesday evening December 3, Dr. L. H. Munn, the newly elected prsident in the chair.

There were present during the evening Drs. Stewart, Mitchell, McGuire, Righter, Longshore, McVey, Hogeboom, Green, R. E. McVey, Peers and Chapman. Dr. H. T. McLaughlin a visitor was invited to take part in the discussion of papers.

Drs. McGuire and Stewart were appointed by the chair to act with Dr. Ward, as censors on the application of Dr. E. C. Chapman, a graduate of the Keokuk medical college, class of 1879, for membership. The report being favorable Dr. Chapman was elected a member of the Academy.

The president in accordance with a resolution passed at the last meeting addressed the meeting. He related that after performing

the gastronomical feat of satisfying the appetite of fifteen or eighteen hungry doctors with oysters, he was able to get their brains in such a condition that they could appreciate the great gratitude he felt toward them for the unsought honor thrust upon him.

The doctor believes the profession overcrowded not with men who deserve to succeed but with those who are unfitted either from non-adaptability to the profession or from a lack of the proper educational foundation, literary and medical.

The young man who contemplates the study of medicine, and the hard working farmer or artizan who is anxious that his son should enter professional life, should understand that the doctor's life is not one of ease and comfort but that it is one full of hardships, and self denial, and that the respect shown the professional man is not greater than that shown the successful business man.

He dislikes the idea of excluding graduates of high schools and academies, but thinks the remedy for overcrowding lies in requiring college training.

Quotes Flint, Eggleston and Doremus as saying that of the 117 colleges in the United States, there are not one dozen that should be tolerated in any country that pretends to be civilized.

Dr. McGuire made a written report of a case of fracture of the superior maxillae, which appears in this issue.

Dr. Hogeboom in opening the discussion on Dr. McGuire's paper, said a similar case came under his observation after the wreck at Streater, Ills. In this case there was not only a fracture of the alveolar portion of the bone, but also a fracture of the malar portion extending over to the nasal bones and causing the face to sink in, producing great deformity. The same kind of a splint was adjusted and the patient recovered without any appreciable deformity.

Dr. E. C. Chapman said these cases if not properly treated result in great deformity, and complimented Dr. McGuire on his management of the case.

Drs. Stewart, Green, Mitchell and Righter, complimented Dr. McGuire on the good results obtained.

Dr. Ward thought the report of such cases as good as a clinical lecture, and also thought it well that we could call in the aid of a dentist. The dentist in this case, Dr. L. A. McArter, he thought deserving of special praise. Dr. McGuire in closing said that generally when a blow was struck of sufficient force to fracture the superior maxillae the result was fatal. Spoke of the inability of using the lower jaw as a splint in this case, and said that generally the same obstacle presented viz.: hemorrhage and inability of the patient to take nourishment.

There being no other paper presented for discussion, Dr. McGuire spoke of the relations of the people and the board of health in regard to scarlet fever which elicited quite an interesting discussion, participated in by most of those present, and resulted in the passing of resolutions warning the people of the danger of the misleading names used and the danger in the way of contagion from even the mild form in which the disease presented itself.

The standing committees for the ensuing year are:

Membership—Drs. Mitchell, Alexander and McGuire.

Finance and hall—Drs. R. E. McVey, Righter and Donaldson.

Constitution and by-laws—Drs. Williamson, Ward and McClintock.

Publication—Drs. Minney, Stewart and Lewis.

Subjects for meeting first Tuesday evening in January, "History and Diagnosis of Scarlet Fever," Dr. T. W. Peers.

"Sequela and Treatment of Scarlet Fever," Dr. W. H. Righter.

D. F. RODGERS.
Secretary.

The N. E. Kansas District Medical Society.

The above society met at Horton, in Dr. Reynold's office, December 3, 1889, the president, Dr. Joseph Haigh in the chair.

The minutes of the last meeting were read and approved.

There were present Drs. Joseph Haigh of Grenada, J. O. Lindsay, H. Grimwell, R. C. Pierce, L. Reynolds, M. R. Hackadorn, M. S.

Brundage, C. C. Stivers, A. X. Campbell, W. W. Ralston of Horton, L. P. Paddock of Netawaka, J. Geiger of St. Joseph, J. C. McClintock, and J. E. Minney, of Topeka.

Drs. Hackadorn, Campbell and Lindsay were appointed censors for the present meeting. Committee on programme Drs. Paddock, Grimwell, and Hackadorn. Drs. Lindsay, Stivers and Ralston, were appointed to draft resolutions relative to the death of Dr. Fisher of Horton, with instructions to report the same to the KANSAS MEDICAL JOURNAL, the papers of Horton and to the doctor's family.

Dr. Haigh delivered an address on medical societies and the general practice of medicine. He urged the importance of physicians reporting their failures as a means of benefit to the profession. He deprecated quackery in this enlightened age and urged that measures should be adopted to prevent it. The advances of medicine and surgery were alluded to with considerable pride, and attributed the success in surgery to cleanliness.

He called attention to proprietary medicines and urged the profession to adopt some means to overcome the necessity of them.

Dr. Paddock—All valuable agents should be used. Antipyrin, antifebrin and salol are not so much used as in the past. New remedies should be discussed. Sulfonal I regard as a safe hypnotic especially in insomnia. Phenacetin is a safer remedy than antifebrin or antipyrin, and hence preferable; hydronaphthol is preferable to iodoform. It is safe and odorless, an antiseptic and disinfectant.

Dr. Geiger—The profession is in need of new remedies. The new remedies have not been so beneficial as I had desired. Iodoform is not a germicide. It prevents initial union. In old abscess cavities it may be beneficial.

Dr. McClintock—While iodoform is not a germicide it does destroy the products of the bacteria, the ptomaines. A new antiseptic dressing—Sir Joseph Lister proposes a new dressing in an address before the medical society of London, November 4, 1889. The antiseptic used being a double cyanide of zinc and mercury, diffused through gauze, and permanently retained therein. It is well known that the mercury held in dressing by glycerine is very readily washed out, and it was necessary to have the salt fixed in the dressing; this is accomplished by the use of starch with the double cyanide. After being prepared the gauze if wanted for immediate use, is passed through a solution of bi-chloride of mercury, of a strength of 1 to 4000, this makes the bulk of the dressing. The layer next to the skin should be washed in a solution of carbolic acid which will soon fly off and leave only the unirritating double cyanide, and under this, not only those wounds which have been brought together, unite beautifully by first intention, but even granulating sores heal by the gradual process of cicatrization from the edges—heal by scabbing in a way that has never before been seen under any other dressing. For the ordinary surgeon, the gauze may be dried. When it will be found that the antiseptic cannot be dusted out, neither can it be washed out in the moist state, and in this lies its chief advantage over other dressings, for the discharges, however free they may be, will not wash away the antiseptic from the gauze.

Dr. Geiger—Bi-chloride of mercury is dangerous and after its use the wound should be irrigated by water previously boiled and used as hot as can be endured.

Dr. Reynolds read a paper on "Intestinal Obstruction," which is published in this number of the JOURNAL.

DISCUSSION.

Dr. Haigh called attention to the treatment of this class of cases by the injection of coal oil into the rectum; he had used it in four cases with success.

Dr. Geiger—More stress should be laid on two points in the paper—one is to diminish, the other to strengthen. He cautioned against too large injections; the bowels are frequently easily ruptured; from one pint to one quart of fluid is sufficient in a child at one time. If the injection remains for some time, use no more for a few hours. Inversion or suspension of the patient until almost worn out, together with stroking the abdomen and manipulation will sometimes disinvaginate; the exact location and character of the obstruction should be ascertained. An early laparotomy should be done. The symptoms are often misleading. Vomiting is usually present and there may be diarrhœa.

Dr. R. C. Pierce—A case of impaction came under my observation, in which the child had diarrhœa, severe pain and was sick for six weeks; finally a dose of castor oil, brought away a large mass of fæces, containing a lump of chewing gum; the child got well.

Dr. Reynolds—The coal oil is only empirical. The character of the stools should not put us off our guard. In the case reported there had been no operation in the bowels for two weeks; one-half gallon of soap suds was injected into the rectum, and the child slept twenty-four hours without an anodyne. About one-third of the lumen of the intestine was involved as shown by post mortem. How do we account for the relief of the child from tenesmus, unless by the bulk of water distending the bowel, thus preventing its action?

The paper was received.

The committee to the Northern Kansas Medical Society reported that a committee from that society had been appointed to confer with your committee at the May meeting.

Report of the committee on program for the next meeting.

"Erysipelas," by Dr. Lindley of Atchison. "Pneumonia," by Dr. Grimwell of Horton. "Ophthalmia," by Dr. Paddock of Netawaka. "Abdominal Surgery," by Dr. Scott of Holton. "New Remedies," by Dr. Ralston of Horton. "Specific Medication," by Dr. Riggs of Muscotah. "Placenta Previa," by Dr. Stivers of Horton. "Membranous Croup," by Dr. Lindsay of Horton. "Antiseptic Midwifery," by Dr. Moore of Effingham. "The Obstetric Art," by Dr. Campbell of Horton. "Inflammatory Rheumatism," by Dr. Graham of Wetmore.

Adjourned to meet in Holton the first Tuesday in March, 1890.

Leavenworth Medical Society.

The Leavenworth Medical Society met November 25th at the Soldiers' Home. Dr. McNary read the paper of the evening on "Lovage as the treatment for Chronic Gastric Catarrh," performing the operation on a patient to show the modus operandi. He advised cocaining the fauces and holding the tongue while the tube was inserted. The stomach was filled with water at a temperature of 90° to 100° in which 30 grains of soda bi-carb. was dissolved; after this had been siphoned out, he filled it with water in which sodæ biborac 30 grains was dissolved and then washed with clear water. The operation was repeated every other day at first. The diet consisted mainly of Bovinine, and for medication he used 5 grain doses of pepsin in scales (P., D. & Co.) and compressed tablets 5 grs. each of ferri proto-carb. Two cases were reported in which eight washings practically changed men from bed-ridden invalids to active laborers. The paper was well discussed by Drs. Carpenter, Wever, Lane, Van Eman and Bidwell. The prevailing sentiment was in favor of introducing the tube without using cocaine or introducing the finger, and one case was reported by Dr. Van Eman in which the patient, a woman, swallowed the tube and washed out the stomach herself, being aided only by a 12-year-old boy.

After refreshments the society adjourned to meet at W. D. Bidwell's office, December 30.

W. D. BIDWELL, Sec'y.

A REMEDY FOR OVER-CROWDING IN THE PROFESSION.—Big Bob Sattoo, the "tenanimous," or medicine man of the Swinomish Indians in the State of Washington, was lately killed by four Indians, a committee of the tribe appointed for the purpose. His offense was that, while responsible for the health of the tribe, he had permitted, or had not prevented, an epidemic which had prevailed among them for some time. It is to be hoped that the practice of burying the doctor with his mistakes will not spread. Such a process of selection is rather too far ahead of the times.—*Medical Review.*

OF A total of 123 deaths in the navy in 1888, sixteen were due to accidental drowning. Of 10,000 persons examined for the naval service, 3,914 were rejected for physical disqualifications. Of this number 130 were rejected for color blindness. The ratio of deaths in the service was 12.35 in a thousand, or about the same as that of a fairly healthy city.

BACILLUS TUBERCULOSIS.—Flick claims that while the bacillus tuberculosis may gain entrance into the lungs by inhalation, that the stomach is the usual mode of entrance.

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TOPEKA, KANSAS, JANUARY, 1890.

A Happy New Year.

Again the holidays, with all their kindly greetings and good cheer are with us. We of THE KANSAS MEDICAL JOURNAL, with the rest of mankind, are filled with joy, and send greeting to the world in general, and the medical profession in particular.

We have not traveled far on our journalistic pilgrimage; we are in the heyday of youth; to us the prospect is bright; we look to the future with hopeful hearts; the achievements of those gone before inspire us with confidence. In our short history as a medical journal we have nothing to regret, but have to congratulate ourselves at the measure of success that has been ours through the generous reception accorded us by the profession. We are publishing a medical journal worthy of the support of the profession, and would urge on every physician who receives it the necessity of becoming a subscriber if not already one, and to use his or her influence to induce others to subscribe, and thus benefit themselves and encourage us in our work. We are in the ranks, at the front and on the march, and we know that if we are faithful workers we will be rewarded by adding something to the advancement of our art. Revivals in medicine are as necessary as revivals in religion. This journal was given to the profession for the promotion and advancement of medical science, that the work of many earnest laborers might be brought to light and preserved in a convenient and permanent form, and that persistent effort might be made to unify the profession.

We think it not out of place in this New Year's greeting, to offer a few words of counsel concerning how we, as members of the medical profession, may best perform our duties both to ourselves and the profession. It is our belief that every physician should be a member of a medical society, and not only a member in name but an *active* member, contributing what he can in the way of new facts, new theories, methods of treatment, and placing them before the society for criticism. To belong to the State Medical Society should be the resolve of every regular physician in the state; but more important is it to be a working member of the local society, with the monthly or semi-monthly meetings, where medical questions are discussed in a scientific manner; where the missing links of important facts are often found that complete the chain of evidence; and not less important, perhaps, is the social feature of the medical society.

Those physicians who are active workers in the medical society, are comparatively free from the asperities and jealousies that are the torment of the "Doctor gone to seed;" that is, the physician whose opportunity to be a worker in the medical society is neglected; who is never known to read a paper or report a case; who shuns the society as though it were an enemy.

Let me urge upon every reader the necessity of commencing this year of grace with the resolve to do something that will benefit himself and the profession; if not a member of a medical society, become one as soon as possible; look over your experience, and if you have something new bring it before your society; if so situated that you can not have the advantage of a local society, write your views in a plain, concise form, and send to the KANSAS MEDICAL JOURNAL.

Let us suppose that every physician in the State of Kansas were to make the year 1890 a year of work, of methodical study, each one an earnest seeker after truth, could we meas-

ure the results? we would have in medicine a a revival such as has not been seen.

We are on the border land of greater advancement, greater discoveries than have yet been brought to light. Let us each one highly resolve that we will make the most of our time and opportunities, remembering that "Art is long and time is fleeting."

The Kansas Medical College.

The JOURNAL has studiously avoided making mention of the college heretofore. The papers of Topeka gave notice of the charter when it was obtained, and have encouraged the undertaking. This is the only notice given, and no reference would be made to the college at the present time but for the numerous inquiries made by physicians from different parts of the state.

This is not because we are unfriendly to the enterprise, but desired that every detail should be perfected before announcement should be made.

It affords the JOURNAL pleasure to inform the medical profession that a legally chartered medical college, designated as the Kansas Medical College, has been organized in Topeka. A faculty has been elected, and a preparatory school for dissecting has been established. The school proper will begin in September, 1890.

It is agreeably surprising to hear the many expressions of encouragement from the brethren throughout the state. The sentiment expressed when the JOURNAL was speaking of the Wichita Medical College, "That every state should educate her own citizens, in the main, in medicine as well as in other professions," is the watchword of success.

There are a few good men who conscientiously deplore this sentiment, but they are gradually becoming convinced of their error, and turning to the paths of advancement. In this connection we mention the good sense of the great mass of medical journals in calling attention to these new colleges in a friendly manner, and are entirely willing that the "fittest shall survive." Occasionally an editor (a professor) is afraid the profession will crowd him out, and he does some *wholly* kicking. This is amusing, especially to a Kansan, for a Kansan does not hunt for, but makes history as well as a state. Kansans are found along the pathway from the rockpile to the speakership of the senate, and worthy and *wearing* the ermine of Chief Justice of the United States.

Our readers will please pardon this little effusion, although we mean it. It is that spirit which has entitled the state, and will entitle the medical profession of the state to that invincible spirit expressed by her motto, *Ad astra per aspera.* J. E. M.

BARBERS.—In these days of antisepsis, when we take a seat in a barber's chair we watch the manipulations of the knight of the razor with a feeling of dread, when the possibility of a cut from the keen blade comes into our minds. The absence of all antiseptic and aseptic precautions are startling to the medical victim in the chair. The physicians should urge upon barbers the necessity of educating themselves in antiseptic barberism.

DR. R. H. FISHER, of Horton, died on the 28th of November, 1889, of septicæmia. He had opened an abscess for a patient on November 19, and used the same lance on himself to relieve his hydrocele, without taking the precaution to disinfect it. Within twelve hours he had a chill, followed by the usual symptoms of septicæmia. Fully half the scrotum sloughed away.

THE next regular meeting of the Republican Valley Medical Society, will be held in the office of Dr. Letourneau, Concordia, Kansas, Thursday, January 2, 1890, at 11 a. m.

Programme—"Chorea," Dr. F. A. McDonald, Aurora, Kansas; "Surgery, Report of Cases," Dr. W. R. Priest, Concordia, Kansas; "Pneumonia," Dr. W. T. Hobbs, Jewell City, Kansas; "Modern Gynæcology," Dr. F. M. Daily, Scottsville, Kansas; "Inflammatory Rheumatism," Dr. D. C. Tyler, Clifton, Kans. Voluntary papers are requested.

J. H. BRIERLY, President,
Glasco, Kansas.

W. F. SAWHILL, Secretary,
Concordia, Kansas.

A Column of Little Things.

COCAINE is recommended in the vomiting of pregnancy.

DR. H. T. MCLAUGHLIN has located at 529 Kansas avenue.

THE eucalyptus tree is said to be a preventive of musquitoes.

SOMNAL is a new soporific. The dose is from 20 to 30 grains.

DR. C. M. MUTZ has hung out his shingle at 606 W. Sixth street.

THE separation of the placenta is favored by tying the cord.—*H. St. C. Gray, M. D., in Practice.*

DR. PHILLIPS, of Salina, was a Capitol visitor last week. He is President of the Central Kansas District Medical Society.

UNCONTROLLABLE vomiting of pregnancy, when all other means have failed, may be overcome by dilatation of the cervical canal by the finger.

FREQUENT examinations during labor, especially during the first stage, after the presentation has been diagnosed as normal, is deprecated by all accoucheurs.

CHLORALAMIDE is the name of the latest new hypnotic. It is a combination of chloral and formanide, and is given in doses of 15 to 60 grains.—*N. Y. Med. Record.*

Dr. G. A. COGGERSHALL, formerly of Ellsworth, Kansas, has removed to Washington, D. C. We are sorry to part with the doctor, as he was in the front rank.

DEATH FROM SULPHONAL.—Dr. R. R. Petitt. of Dayton, Ohio, reports in the *Medical News* a death from the administration of two 15 gr. doses of sulphonal, given one and a quarter hours apart, to a woman aged 28, who was suffering from melancholia.

ABORTION OF ACUTE CORYZA.—According to Dr. Bishop, of Chicago, a tablet containing $\frac{1}{2}$ grain of morphine and $\frac{1}{100}$ gr. of atropia, divided into four equal parts, and are given every hour until the effects of the atropia is induced, will break up or abort almost any attack of acute coryza.

THE November No. of the JOURNAL contained an article by R. E. McVey, of Topeka, read before the E. K. D. M. Society, at Leavenworth, in which from purely physiological reasons, he advocated the use of albuminous foods in the dietetic treatment of Bright's disease. Dr. McNary, of the Soldiers' Home, confirmed the plan of treatment by experience in some reported cases:

"Prof. Schreiber, of Königsberg, experimented on eight people suffering from kidney disease, to whom he gave along with their ordinary diet six to ten eggs daily. Before the beginning of the experiment they had been under observation from four to eight days, on the usual diet, until the fluctuations in the amount of the albumen in the twenty-four hours had been determined; the estimations being likewise made for several days after the eggs were discontinued. In four of the cases the eggs were administered boiled; in the others raw. In the former group the patients received six eggs daily and in none of them during the period of administration of the nitrogenous food could any fluctuation or increase in the amount of albumen be determined. In the second group, six to ten raw eggs daily, not only did not show an increase in the excretion of albumen, but actually led to a considerable diminution. Similar results have also recently been recorded from Leyden's wards. These observations also agree with those of Oertel, who has stated that the addition of a great quantity of albuminous food may affect albuminuria favorably."—*Med. Record.*

The above agrees with the ideas expressed to us by Dr. McVey for a long time, in the treatment of Bright's disease, and contained in his paper to which reference has been made. More particularly was this noted from the teaching as we believed being opposed to such diet. His reasoning we could not overthrow, but thought the weight of authority against him, and rested content. We are glad to note from time to time, brethren in our midst who are capable of leading in advanced thoughts in medicine. J. E. M.

DR. DAVID PRINCE, of Jacksonville, Ill., one of the best known surgeons in the West, died at his home of pneumonia, December 19, 1889.

Encouragement.

"Enclosed find two dollars subscription for the KANSAS MEDICAL JOURNAL. I am much pleased with it and consider it a credit to the profession in Kansas.

"Yours fraternally,

"J. A. WHITING, M. D.,

"Milford, Kan."

The above is a specimen of the kind words and substantial tokens of esteem in which the JOURNAL is held.

CURETTING FOR DYSMENORRHŒA.—The operation may be performed upon the bed, without assistance and without narcosis. After thorough washing out of the vagina, the uterus is drawn down by a bullet forceps, and the uterine cavity is gradually curetted by a long-handled sharp spoon. Then the cavity is washed out with Bozeman-Fritzch's catheter, when an injection of ferrum chloridum is made. The curetting must be performed thoroughly and systematically. The patient must remain in bed a week after the operation, with water-compresses or ice-bags upon the abdomen. Contra-indications—para and perimetritis; incomplete knowledge of antiseptics by the operator.—*Arch. Gynæcology*.

THE publisher not having room in the December number of the JOURNAL for all matter furnished by the editors, took out the proceedings of the South Kansas Medical Society, Notes from Kansas City, Notes on Rheumatism, &c., without our knowledge, and hence references and omissions which refer to nothing, and seemingly careless omissions are accounted for. Hereafter unison of thought will prevail in making up the subject matter of the JOURNAL.

THE *N. Y. Medical Times* says: "The oil of bay is used by the butchers of Switzerland to keep their shops free from flies. After a coat of oil has been applied to the walls none venture to appear. It also prevents gilt frames, chandeliers, &c., from becoming soiled by the flies."

We are anxious for the fly season to come again to prove the correctness of the above.

INFANTILE convulsions, or spasms, may be arrested in one minute by the application of one or two dry cups on the back, from the seventh cervical to the first dorsal vertebra. This secures a remission for other medication. —*Daniel's Texas Medical Journal.*

A CASE of antifebrin poisoning is reported by Dr. Robert Haley, of Brookfield, Mo., in the *Weekly Medical Review*. The amount of antifebrin taken was 48 grains a day for about three days. A fatal result was averted evidently by prompt treatment.

THE following communication from the *Health Monitor*, of Denver, Colorado, has been received:

EDITOR KANSAS MEDICAL JOURNAL:—The *Health Monitor* would be pleased to exchange with the KANSAS MEDICAL JOURNAL. If all your numbers are as good as the one I saw, it is one of the best journals published.

Very respectfully, &c.,

C. E. BRYANT.

DR. G. W. EARLE in the *Br. Gyn. Journal*, in summing up the treatment of eclampsia during labor says: "With the present light on the subject, it appears to me that for convulsions at full term the hot bath, anæsthetics, and a termination of labor as rapidly as could be done without injury to the soft parts, is the treatment for to-day.

AGAIN.—The *Times and Register* of Philadelphia, in its weekly list of important and practical articles, gives the KANSAS MEDICAL JOURNAL credit for two such articles in October, viz.: "Tertiary Syphilis and Treatment—Dr. McVey; "Uterine Hyperplasia"—Dr. McCandless.

A CHICAGO professor has found in that city that the hair on the mons veneris of sterile women is straight. He does not advise curling the hair as a cure for sterility.—*Arch. Gynæcology*.

IN the vomiting of pregnancy, Prof. Sharp recommends small and repeated doses of dilute hydrocyanic acid.

GUNPOWDER FOR CRIMINAL ABORTION—The Kansas City *Medical Record* says that "Dr. ———, world without end—vsky—reports two curious cases of criminal abortion caused by the internal use of gunpowder, in the dose of a small sized wine glass full. The fœtus was expelled in a few hours after the injection of a single dose."

A case of criminal abortion came under the writer's observation in which a tablespoonful each of gunpowder and iron filings (the woman's husband was a blacksmith,) was taken with equal effect. A two months fœtus was expelled within four hours from the time of ingestion. The woman recovered in the usual time without any complications, contrary to our prognosis. J. E. M.

Dr. W. D. BIDWELL, A. M., M. D., of Leavenworth, and one of the associate editors spent a few days with the mast-fed editor of the JOURNAL. The Doctor made himself useful as well as ornamental, assisting Dr. Alexander and myself in trephining the mastoid. Come again, Doctor, and do likewise.

"GYNAIA," A NEW DISEASE.—A Dr. Steinerkopf, who may be some relation to Dr. Holzerkopf, or perhaps Dr. Dammkopf, has discovered a new disease which he calls "gynaia," and which he defines as "the simulated existence of feminine moral qualities in the person of a man."—*N. Y. Med. Record.*

THE JOURNAL is under obligations to the *Western Dental Journal*, of Kansas City, Mo., for the use of the cuts contained in Dr. McGuire's article on pages 297, 298 and 299 of this number.

CORRECTION.—In Dr. Harris' article in the November number, on "Changes in Fevers," page 274, in 2d column, eighteenth line from the top, *convincing* should read *commencing*.

DR. L. Y. GRUBB of Topeka, will spend the winter in Los Angeles. We hope that the Italian climate of the Pacific coast will more than meet the doctor's expectations.

PROF. S. S. TODD of Kansas City, and Miss Frances Williams of Lucas county, Iowa, were married on the evening of November 9.

ALARMING RESULTS FROM A SINGLE DOSE OF ANTIPYRIN.—Mrs. S——— was suffering from a severe headache, and diagnosing her case to be similar to Mrs. F———'s she took one of the powders which had been ordered, one every four hours, for Mrs. F———'s headache. The powders were antipyrin, fifteen grains in each. Within five minutes she began to sneeze violently and a free watery discharge came from the nose. The throat seemed to swell and close up and the patient had fears of suffocation and impending death. Emesis was promptly secured by mustard and hot water, and half an hour later the only symptom remaining was hoarseness.

Mrs. S. is of a nervous disposition and had been very much worried during the day, which doubtless augmented her sufferings.

Some patients experience a sharp pricking sensation in the throat, but this is the most severe case of the kind that has come under my observation. W. D. B.

SINCE the elixir discovery, the faculty of the Kansas City Medical College has been stimulated to greater exertion. Drs. Todd, Halley and Beattie have all committed matrimony. This is as it should be. The JOURNAL extends congratulation. The world would be more nearly evened up if one or two more of the faculty would do likewise.

"DR." DIAMOND DICK, one of the most successful Western peripatetic, cash-in-advance cure-all medicine venders has rented a large hall in Kansas City and will give the M. D.'s of that burg a lesson in transferring money from the pockets of the dear people to his own.

THE Topeka Academy of Medicine and Surgery meets in Lincoln post hall the first Tuesday evening of each month. Visiting physicians cordially invited to attend.

LEAVENWORTH has a colored physician to whom most of the practice among the colored people is turned over.

One of the best gargles in acute sore throat is hot claret wine. It is agreeable as well as astringent.

THERAPEUTIC NOTES.

CORYZA—KARA, THE HEAD, AND ZEO, I LIVE.

In the treatment of coryza a great variety of remedies have been used and recommended, more than a careful study of its etiology and pathology approves.

The causes of coryza are numerous. Among the most common are a partial application of cold to the body, or to the feet, the hands, the head, &c., especially when there is the feeble cardiac action following exhaustion. The ball-room furnishes many victims, especially among the ladies, who, after the exhaustion of the dance expose their half-clad bodies to the cold. In its day the skating-rink furnished its share among those who took its vigorous indoor exercise and then went out into the cold, or sat in a draft to cool off. Paper-soled shoes are a prolific cause of coryza. A sudden change from an extreme cold to a warm atmosphere causes the disease in much the same way that it produces chilblains. Specific poisons, as of rubeola, irritants; irritants, as tobacco, acrid vapors and powders; epidemic influences, climatic changes, idiosyncracy, &c., all tend to produce local irritation and hyperæmia of the nasal membrane, which manifests itself by obstructed nasal respiration, fullness, heat and pain, with such reflexes as sneezing, headache, &c., speedily followed by a watery mucoid discharge.

The pathological expression is amenable to a variety of treatment, but the first care should be to remove the cause. Apply warm clothing to the whole body, especially the feet, and avoid extreme and sudden changes in temperature.

Among the remedial agents we mention cocaine, applied topically in a two to four per cent. solution.

For the same purpose Dr. Physic recommended the inhalation of the vapor of laudanum and Hoffman's anodyne, āā., and Deschamp's snuffing into the nostrils a solution of extract of opium, one grain to the ounce.

Chloroform, (chlorodyne) poured into the hand and inhaled frequently, often give prompt and perfect relief.

Dr. Chapman prescribed a full dose of opium at bed-time.

A better prescription is, ℞, opü, ipecac., āā. grs. j, brom. potass. gr. x., m. s. d. at bed-time, preceded by a saline cathartic and a hot pediluvium. Many physicians give at bed-time quinine and Dover's powder, āā. grs. x.

In domestic practice a good substitute is found in a bowl of hot bone-set (eupatorium perfoliatum) tea, fluid ext. gelsiminum gtta. xv. at bed-time often acts like a charm.

Ten grains of antifebrine, or seven of antipiryne, are in fashion now.

More complicated formula, one often used is

℞.	Potass. nitras.	ʒj.
	Aqua pur.	f ʒij.

Dissolve and add listerine—Lamberts, f.ʒj.m.

Sig. Use with an atomizer three times a day. A sure cure for nose cold and nasal catarrh.—*Phil. Med. Bulletin.*

℞	Roasted coffee,	50 parts.
	Menthol,	2 parts.
	Sugar,	50 parts.

Triturate together into a fine powder and use as a snuff.—*Post Graduate Journal.*

℞	Carbolic acid, alcohol, āā.	10 parts.
	Listerine,	20 parts.

M. Fill a 2 oz. wide-mouthed bottle ⅓ full; introduce sufficient absorbent cotton to absorb the whole; keep corked and ready for use by inhalation.—*K. C. Med. Record.*

℞	Ammoniæ chlord.	ʒij.
	Ext. glycirrhizæ (liquid),	ʒiij.
	Syr. prun. virg.	ʒij.
	Syr. ipecac.	ʒiij.
	Aqua pura,	ʒiij.

M Sig. D. A teaspoonful every 3 hours.

Good medication without medicine will be found in a dry-bath—free friction with a coarse towel until the whole body feels like polished ivory.

Dr. Williams recommends total abstinence from liquids.

The logic of this treatment is improved by adding total abstinence from food for a few meals. The stimulating quality as well as quantity of the circulation will thus be diminished. This is good treatment in the first stage of many diseases, as the organism thus relieved of the ordinary duty of digesting, appropriating and eliminating can perform the extra duty of depurating.

Instead of this course we sometimes find the

opposite commended—"stuff a cold"—force a balance. Very good if it succeeds, if not there will be opportunity to "starve a fever." Inhaling aqua ammonia acts locally upon the same plan.

Where there is predisposition to coryza, a cold bath to the neck, chest and back every morning, will be found an excellent prophylaxis.

AN "INFALLIBLE ANTIDOTE" FOR MALARIAL FEVERS.

Dr. Charles G. R. Naylor, Civil Surgeon, of Burmah, India, addresses a report to the Deputy Surgeon-General of British Burmah in which he asserts that carbonic acid gas is an infallible antidote to malarial fevers of all types and durations. Dr. Naylor's report is re-published in Edinburgh. It was first made eight years ago, but is now put forth again in an enlarged form and with the emphasis and confidence drawn from a fuller experience.

Dr. Naylor does not claim originality for his treatment. It was devised or discovered by Dr. John Parkin, of London, who tested its value while visiting the malarial districts of Italy, Spain, and West Africa.

The *rationale* of the gas treatment is expounded by Drs. Parkin and Naylor, but it is far from being satisfactory or scientific and it need not occupy our space.

The gas is administered in solution and is got in its cheapest form by dissolving bicarbonate of soda, gr. xxx., in three ounces of cold water, and throwing into the solution tartaric acid, gr. xx., in a powdered state, the mixture to be stirred rapidly once, and swallowed as soon as possible in a state of effervescence. The patient must be made to lie down immediately after, to prevent eructation and escape of the gas, so apt to occur in a sitting posture.

The doses of soda and acid must be decreased to suit the different ages of children, as gr. xxx. of bicarbonate of soda are not soluble in the small quantity of water suitable for administration in one dose to very young children.

Sometimes the soda is given first and followed by the acid.

The remedy is best administered just before the paroxysm is expected, or in the remission if the case be one of remittent fever. Dr. Naylor cites a long list of cases cured by gas.

PHENACETIN.

Phenacetin is one of the latest antipyretics that has come into professional favor; and although it is closely allied in action and in chemical composition to its twin sisters antipyrin and antifebrin, clinical experience teaches that it possesses certain peculiarities which places it in the front rank of this class of remedies. Like the two latter, it is not only useful as a fever reducing agent, but it also displays a remarkable beneficial influence in diseases of the nervous system. It is indeed very probable that all these substances exert their therapeutic properties by virtue of their strong affinity for the nervous system; notwithstanding the fact that this feature was altogether unobserved when they were first introduced to the profession. It is always a cause for much congratulation, because it is an indication of normal development, when, as in this instance, independent researches, carried on in the different branches of the same science, yield evidence of a reciprocally confirmatory character. Previous to the discovery of the antipyretic action of these coal-tar products, there were investigations in progress which showed both from an experimental and a clinical standpoint, that the essential lesion of fever consisted in a disordered state of the heat-regulating centres of the nervous system. So long as fever was believed to be due primarily to super-oxidation of the bodily tissues, as was taught by the older pathology, the *modus operandi* of every antipyretic was more or less enshrouded in a cloud of darkness; but when subsequent observation demonstrated that phenacetin and its allies produced antipyresis by reason of their marked affinity for the nervous system, the neurotic theory of fever was so much richer on account of the additional evidence which it received from this quarter.

Whatever its manifestation may be, therefore, it is clear that the fundamental action of phenacetin is concentrated on the nervous system, and it is well to bear this feature of its action in mind while administering it. As an antipyretic it is in many respects superior to

either antipyrin or antifebrin. This is true of it in acute as well as in chronic fever. In the experience of others, as well as in our own, it has been known to reduce acute fever in cases in which both of the latter agents had signally failed. Not only does it appear to be the most effectual antipyretic, but it also seems to be free from producing any toxic effects unless it is given in very large doses, while both antipyrin and antifebrin are prone to give rise to these—the former to a cutaneous rash, and the latter to a cyanotic condition of the blood.

Phenacetin is especially valuable in suppressing the fever of pulmonary consumption. In this as in every other chronic form of fever, large and probably double doses are required to achieve the same end as that which is obtained in acute fever. Of course no iron-clad rule can be laid down as to how much should be given in any individual instance. The best guide that can be followed is to give it "for effect." If four or five grains administered every four hours do not suffice to bring down the temperature, there should be no hesitation in giving from ten to twenty grains. Ordinarily it will be found, however, that from five to ten grains is all that is required in such cases. It also has a modifying influence on other symptoms of this disease. Simultaneously with the reduction of fever, the cough becomes easier, the expectoration diminishes, and a general improvement in the patient's condition follows. From this it will be seen that phenacetin does good, not only as an antipyretic in pulmonary consumption, but also as a constitutional tonic—a *role* which it undoubtedly plays through its action on the nervous system; and for this reason it renders useful service, and its administration should be continued in three or four-grain doses three or four times a day after the fever has abated.

That which is true of phenacetin in pulmonary consumption also holds true in chronic bronchitis, whooping-cough, migraine, neuralgia, neurasthenia, &c., when it is given in three or four-grain doses; and from all appearance it bids fair to out-rival antipyrin and antifebrin in the treatment of all adynamic conditions of the nervous system.—*Medical and Surgical Reporter.*

MEDICAL MISCELLANY.

CLINICAL NOTES & GOSSIP
From Kansas City Medical College.

Reported for Kansas Medical Journal.

BY R. S. MAGEE.

Prof. Van Eman, clinical lecturer of practical medicine, details regularly two members of the senior class to a ward of the city hospital, assigning them a case, and requiring in writing a complete and thorough diagnosis, prognosis and outline of treatment, with reasons for same, to be presented to him within one week, and read before the class. This is meeting the actual, practical work face to face.

It is with pleasure we record the marriage of our senior surgeon, Prof. Halley, and two of our graduates. We extend our heartiest congratulations and best wishes for prosperous futures.

Dr. W. J. Beattie, of the class of '85, and Miss Clara Choteau, of this city, were married on the evening of October 2. A tour, including Washington and New York cities, being gone about two weeks. Dr. Beattie is one of our demonstrators of anatomy, and secretary of the *alumni*.

Dr. J. R. Atchison, class of '86, and Miss Maggie Tillman, of Dover, Kansas, were married October 30. The Doctor resides at Edgerton, Kansas, and has a good paying practice.

Prof. Tyree, in speaking of foreign bodies in the vitreous chamber, said that they were a source of great danger. They will set up inflammation of the vitreous, and through the ciliary nerves set up irritation in the fellow eye, leading to inflammation and its destruction. If it is known to be a piece of iron or steel, a powerful magnet may be of great service in its removal, under the following conditions:

1. If the wound be recent.
2. Before foreign body encapsulates.
3. If wound is in the sclera.
4. And especially if foreign body is in anterior chamber.

If the lens is pierced by the foreign body,

the distance the latter would have to be withdrawn through the dense, firm substance, would render the use of the magnet impracticable. The lens, in this case, should first be removed. The form of magnet used is an electro-magnet, with a variety of different sized points; any desired strength can be had by increasing or decreasing the number of cells. It may be necessary to enlarge the scleral wound to admit the blunt point of the magnet, which, when introduced, should be carefully moved along the edge of the wound. If this fails, it may then be passed on into the vitreous, in the direction the foreign body has taken. If you do not succeed, enucleation is your only recourse, especially when there is no vision left in the eye.

Prof. E. W. Schauffler, in a recent lecture on phthisis, said that many of the teachers of our own land are still quite cautious about committing themselves to the new doctrine of the bacillar origin of phthisis. But I believe medical sentiment is drifting that way, and that soon no one will teach anything else. Twenty years' ago Niemeyer, the champion of "Catarrhal Phthisis," said, "The great danger to the phthisical patient is, that he may become tubercular." To-day we reiterate this statement, in substance, with a somewhat more correct idea of what it means, and would say, *the great danger to a patient with areas of consolidation in his lungs, of whatever origin, is, that they may become invaded, if they are not so already, by the tubercle-bacillus.* In adopting this view I by no means reject the teachings of clinical experience, and of the post-mortem table, to the effect that many cases of phthisis, evidently follow catarrhal, or sometimes croupous pneumonic processes, giving no evidence, post-mortem, of the presence of tubercular nodules. The Doctor summed his position as follows:

1. The tubercular nodule is no longer the criterion of tuberculosis, but this criterion is always and only the tubercle-bacillus.

2. The areas of consolidation following bronchitis, lobular catarrhal pneumonia, or sometimes croupous pneumonia, are liable to be invaded by the tubercle-bacillus, and then phthisis is developed.

3. Tubercular nodules, probably developed under the influence of the bacilli of this name, are often the primary lesion of phthisis.

4. Fibroid phthisis is always an evidence of an attempt at repair. When it fails longer to limit the disease, tubercle-bacilli are found in abundance in the necrotic tissues.

The tubercle-bacillus is a minute rod-shaped fungus, measuring from 0.0035 to 0.003 millimetre in length, and about one-third that measurement in thickness. The rods are straight or slightly curved, with rounded ends. After having been stained with methyl-blue or fuchsin, and then washed in nitric acid, (ten per cent.) they retain the original stain, and thus distinguished from any putrefactive or other bacilli.

Inflammation of the sebaceous follicles of the vulva is frequently caused by acrid discharges from the uterine cavity. The orifice of vagina becomes very sensitive, accompanied by an intense pruritus. An eczematous eruption, covering the labia and upper part of the thighs frequently appears. In the treatment of the above, Prof. Todd recommended the following:

℞. Tr. Iodini Comp.
Sat. Sol. Acidi. Carbol. āā f ʒj.
Glycerini f ʒij

M. Sig. To be applied locally to the parts.

Two or three applications at an interval of three or four days, will generally effect a cure. The application is too powerful to be applied more frequently. It occasions some smarting, which ceases after a few minutes, leaving the patient quite comfortable. In the interval the patient should be directed to use the following as an injection and lotion to the parts three or four times a day:

℞. Sodii. Hypo. Sulph. ʒj.
Aquæ Dest. ʒij.

M. Ft. Sol.

This is a germicide, and soothing in its effects.

A SERIES of experiments, conducted by Dr. Jos. J. Kinyoun, of the United States Marine Hospital Service, showed that the ordinary method of cleansing the hands and nails by scrubbing with soap and water, and then washing in a 1 to 3000 bi-chloride solution, as employed by nurses in the service, did not render

them surgically clean. Scrapings from the hands and from under the nails gave rise to colonies of bacteria, more particularly the staphylococcus pyogenes, in nearly every instance. Satisfactory cleansing was only obtained when the hands were scrubbed with soap and water, immersed five or six minutes in alcohol, and an equal time in bi-chloride solution 1 to 1000 or stronger. Better results were obtained when bi-chloride was added to the alcohol in the proportion of 1 to 3000, and the solution in water made of a strength equal to 1 to 500.

An Unusual Treatment for Acute Articular Rheumatism.

Dr. W. H. Carruthers, at the June meeting of the Minnesota State Medical Society, 1889, in his report on "Rheumatism," says:

"I believe anything that will combine the two objects I have indicated, viz., reduce temperature and change the blood to an alkaline condition as soon as possible, are the indications for treatment.

"My experience has led me to believe that I have a good plan of treatment. I shall not say the best, but one that has been the best in my hands.

"I wish to report a few cases with the results of my treatment during the last three or four years. Having used the treatment laid down in our books with the usual results of having my cases last from ten days to three weeks, I tried the use of ice cold applications to the inflamed joints and the salicylate of soda internally. My results have been the most satisfactory, and I shall only occupy your time for a few minutes while I give results in a few of the worst cases I have met since following this plan.

"My first case was a man with both knees and one ankle inflamed; I gave sod. salicylate 15 gr. every two or three hours. Towels taken from ice cold water and applied every five to ten minutes, or as fast as they became warm. His temperature 104°, at my visit next morning was 100°, pain and swelling nearly gone, having entirely disappeared by next morning.

"Case 2.—Mrs. M—— had been sick for two weeks with rheumatism, but considered well by her physician, who had dismissed the case. The next night she sent for me. I called at midnight on my return from other work to find her suffering greatly with an inflamed knee, high fever, and knee apparently so tender she could or would not be moved, or hardly touched. I directed cold towels applied to the knee. She evidently thought I must be either drunk or crazy, as I was a stranger to her. But her husband, thinking the doctor's word must be law, set about carrying out my directions. At my morning visit pain all gone and swelling going, temperature about normal. I kept track of this case for two or three years, and she had no more attacks. I speak of this as some claim after salicylates relapses are frequent. I have not found it so in my cases.

"Case 3.—Mr. G——, an elderly man, with right wrist and elbow, and left elbow and shoulder afflicted. I directed, as usual, soda salicylate and cold water; when he found how much relief he obtained he got some snow which he put into towels, and packed that about his sore joints. At my second visit he was only complaining of a little stiffness of the afflicted joints, which had all disappeared by the next day, and he went to his office.

"Case 4.—Miss M——. In this case I was not so successful, but it will do to point a moral. When I called, I found her with her wrists and knuckle joints, and one ankle afflicted. Her temperature was very high, about 105° I prescribed as usual, and at my second call found no improvement. I was surprised, but on close inquiry found that the cold had been applied not more than two or three times since my last visit. I made a few pointed remarks, and received a note in an hour or two telling me I need not call till sent for. As I have never been sent for, have not called yet; but I learned the lady had a good homeopath to attend her, and remained in her bed almost a month.

"Case 5.—An Irish lad of fifteen years. His left wrist, knuckles and elbow, left knee and ankle, and his right knee. I never saw anybody so bad with rheumatism before or since. His temperature was nearly 106° I prescribed sod. salicyl. in 10 gr. doses and ice cold applications at once. I met some opposition, as a

young lady present said she had once been sick seven weeks with the same trouble, and they used warm flannels; but a neighbor, whose confidence I had, went in and set to work to carry out my directions. He told me that he heard the boy crying from the pain when two blocks from the house; but in twenty minutes after using the cold to the joints he became quiet and rested well all night. At my call, fifteen hours after my first, I found him sitting in an easy chair with his temperature 100½°, pain all gone and little swelling. In two days more he was about his work.

"My last case, which I wish to report, was a German woman. When I first saw her, her right knee was enormously swollen and very painful. She lived in the country, so could not readily get ice, as it was summer time, but she began using water from the well; that was about ten o'clock in the forenoon. Being at her neighbor's at 8 p. m., I ran in to see her. She had as she said 'gone to bed for the night.' She had taken quite a large piece of ice which she had procured somewhere, under her knee, and several small pieces wrapped in a towel laid upon it. I thought if she could stand it I could. When I called next day she was about the house at her work.

"These are some of my worst cases treated in the last three or four years, with the ice water packs about the inflamed joints. None of them had relapses, and most of them I have known to be free from any attacks of rheumatism since. Not one has had the least sign of heart complications.

"Dr. Bartholow says, 'The acute stage of a rheumatic seizure, if the first one, is not often terminated in an earlier period than two weeks, and is more frequently prolonged to three or even four weeks.' Mr. Fuller's cases show under the alkaline carbonates, an average of eleven days, with only two per cent. of heart inflammations. While I have not a hundred cases to report, I feel sure if carried out carefully, I can show as good results for hundreds of cases. The average duration of my cases was between two and three days, and with no heart complications, is as good a result as I could wish.

"A word of caution: An old friend of mine used to say to me when I was a boy and wo ing for him, 'anything that's worth doing a all is worth doing well.' Don't apply cold in any other way but *well* and *thoroughly*."

Rascality in Medicine.

The man who offers to sell his wares cheaper than his neighbors, using the large type to call attention to his liberality and business tact, and then fails to satisfy his customers, either giving short weight or inferior goods, soon comes to be called dishonest and loses the confidence of the trade. The politician who makes promises to his patrons of retrenchment and reform in the administration of affairs of which he may have the management, and then proves false to these promises, soon loses his prestige and standing. Why not carry this principle into the every-day business of the doctor, one who stands as high, or should, as the representatives of any other business, and demand the same honesty and integrity in our dealings with life and health, as in commercial and political matters. The doctor who auscultates and percusses a slightly inflamed lung, or irritable heart from indigestion, gives a nasty mixture, with a very unfavorable prognosis, alarms the friends, and then convinces them in a few weeks that he has performed a wonderful cure, nine times out of ten is an impostor. This same man is always finding and removing cancers, tumors, malignant growths, and magnifying simple surgical operations which are performed silently and skillfully by nearly every physician in the country, into wonderful examples of skill and knowledge, and all the old women in the neighborhood are constantly sounding his praises, while the really honest and conscientious practitioner is obliged to keep silence in the matter, on penalty of being called jealous and envious of this wonderful man's reputation. Such men are a disgrace to the profession of medicine, and should be exposed by all of us in a way to cause their downfall. We all know men of this character. Pulverize them.

G. C. IRWIN, M. D.

EFFECTS OF OUR LATE WAR ON SOLDIERS —Dr. Coe, in the *N. Y. Medical Journal*, calls

ttention to the fact that nearly all the prominent generals on both sides of the late war have died prematurely. He says that observations made during three years' service in the late war, and a service of several years as pension examiner since, indicate that those soldiers who bore the tremendous hardships and privations of the field without becoming disabled thereby, have since become prematurely old and decrepid, some of them without any assignable cause save the premature expenditure of the reserved vital forces; others from faulty nutrition, indicated by degeneration or sclerosis of the spinal cord and arteries, and resulting disease of the heart, and chronic rheumatic troubles affecting mostly the spinal and sciatic nerves.

Dr. Kunze, in his inaugular thesis for the M. D. degree in the University of Kiel, publishes as a contribution to the diseases caused by the inhalation of dust a series of examinations of lungs so affected. In all these dust was found microscopically, and after chemical tests in the various anatomical and histiological parts of the lungs, and in the anterior of the lymphatic vessels, numerous leucocytes were found covered with the dust. Being arrested in its progress it causes inflammation, producing hyperplasia of connective tissue, especially where a dense network of lymphatic vessels exists. Dr. Kunze also proved that the degree of alteration in so-called "dust lungs," depends not merely on the quantity of the dust inhaled, but also on its greater or less morphological power of injuring the tissue. He concludes from his experiments that even the greatest alterations in these lungs—such as nodes, indurations, and vomicæ—are mainly produced by the inhaled dust, and that tuberculosis is only an occasional coincidence. The least serious alterations in the lungs resulted from the inhalation of lamp-black, the particles of which are very fine and little injurious; the most serious, from dust inhaled by earthenware manufacturers and stonemasons. The lungs of a locksmith showed only a moderate hyperplasia of connective tissue, the dust consisting partly of the finest particles of iron. In a worker in oxides of iron the lungs were found full of small granules, and the morbid changes in the tissues were very considerable. The lungs of gold miners were generally indurated and atrophied; the dust in these cases is exceedingly fine. Sand produced numerous circumscribed hard nodules and thick indurations. In cloth manufacturers, the lungs, in spite of their contact with an enormous quantity of organic dust, presented but few indurations. In the lungs of two stonemasons induration and tuberculous disintegration were observed; all the other lungs were entirely free from tuberculosis of any kind, an observation which was verified by the absence of tubercle bacilli in the muco-pus in the vomicæ. —*Lance.*

THE California State Board of Health has stirred up a hornet's nest in the southern portion of the State by protesting against consumptive patients being invited to come there. The board insists that the mingling of a large number of patients with consumption among the healthy is a menace to the health of the latter, urging that "consumption is never contracted except by association or by living in close proximity." The board does not attempt to interdict immigration, but points out the danger involved. The danger from sputa is unquestioned, and it is to be hoped that the disuse of handkerchiefs for spittoons will soon come about, and that only proper receptacles, frequently disinfected, will be used for sputa.

The usefulness of good Hypophosphites in pulmonary and strumous affections is generally agreed upon by the profession. We commend to the notice of our readers the advertisement on page xii of this number. "Robinson's Hypophosphites" is an elegant and uniformly active preparation; the presence in it of quinine, strychnine, iron, etc., adding highly to its tonic value.

DR. CHARLES ADAMS, of Kansas City, deserves credit for reporting the cases in his paper in this number of the JOURNAL. It requires nerve to report our failures. The physician who claims he has no failures, either has an extremely limited experience or lies. That man can be trusted who on proper occasions reports his failures that the profession may be benefitted.

THE "PHYSICIAN'S ANATOMICAL AID," by the Western Publishing Co., of Chicago.

Notice the advertisement on page xvi for description. This is without doubt the finest thing in its line ever brought to our notice. The plates are exceedingly fine and the arrangement perfect, while its form is such as to give at once the greatest advantage for display and the greatest security from injury. For the teacher, the student or the practitioner we could recommend nothing better for the purpose unless it should be the cadaver. The price is comparatively low, and the terms very reasonable.

Therapeutic Notes of Some of the Newer Medicaments.

CONDURANGO WINE.

Although condurango has not entirely justified the claims made for it in the treatment of cancer, the experiments made with it have demonstrated its utility as a stomachic, and in the form of condurango wine it has grown to be very much in demand, especially in Europe. One fluid ounce of the wine represents sixty grains of condurango bark. Dose, one-half to one fluid ounce. Parke, Davis & Co. supply the wine, and also a fluid and solid extract of this drug; and will also mail, on request, a working bulletin on condurango to physicians who wish more detailed information concerning it.

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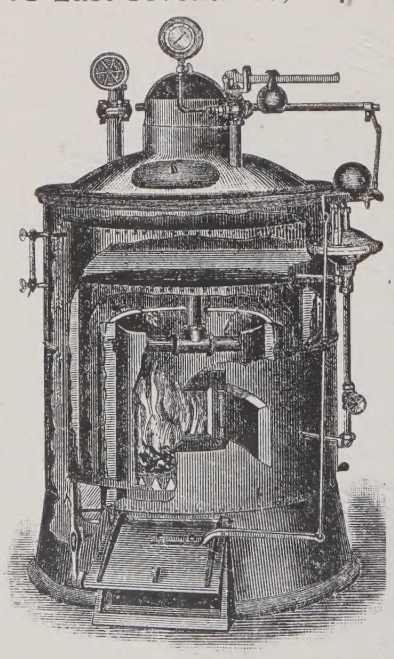

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